MAY 15 1999

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

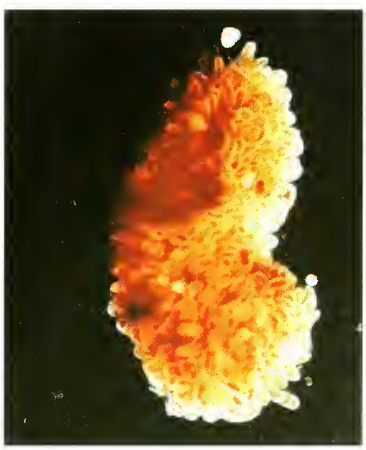
Boots rolls out clinical services for GPs

RPM under attack from Asda again

GPs win latest round in Notts rural dispensing row

AAH Vantage pushes the benefits of the virtual chain

Importers fight PPRS threat to PIs



Update: *gluten for punishment in coeliac disease*

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Benadryl Allergy Relief starts working in just 15 minutes. Because it starts working so quickly and lasts for up to 8 hours, your customers only take it when they need it. Its non sedating profile and excellent safety record makes it suitable for most Hay Fever sufferers. No non-drowsy allergy relief tablet works as fast, so the faster you recommend it, the faster they'll start to feel better.

No non-drowsy allergy tablet works as fast.

Presentation: Capsules containing 8mg Acrivastine. **Uses:** Allergic rhinitis and allergic skin conditions. **Dosage:** Adults and children over 12: one capsule up to 3 t a day. Not for use in the elderly (over 65 years). **Contra-indications:** Hypersensitivity to Acrivastine or Triprolidine or renal impairment. **Precautions:** It is usual to a patients not to undertake tasks requiring mental alertness while under the influence of alcohol and other CNS depressants. Caution during pregnancy. **Side effe** Reports of drowsiness are extremely rare. **Price (ex VAT):** 12s £3.46, 24s £6.01. **Legal category:** P. **Licence holder:** Warner Lambert Consumer Healthcare, Ches Avenue, Eastleigh, SO53 3ZQ. **Product licence number:** 15513/0035. **Date of preparation:** March 1999.

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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REGULARS

COMMENT

Two clear messages came out of last week's AAH Convention. Firstly, pharmacies need to develop income streams which do not depend on the NHS. This means increased sales from better front shop management, or the development of speciality niche markets where pharmacists can maximise their professional skills. Secondly, independent pharmacies are going to become more dependent on services managed by other people, be it a computer network provided by their IT supplier, or the packages offered by whichever wholesaler or symbol group they happen to belong to. There has been plenty of recent evidence of the expansion of the professional niche market (*C&D* May 1, p5), and with Boots this week announcing a clutch of clinical services which it is promoting to GPs (see p4), the competition is hotting up. It is not impossible (but it is difficult) for an independent to be an expert front shop manager, to develop professional services, and to keep an eye on 'bread and butter' NHS income (although 'bread and water' might be a more accurate description). Take advantage of our tailored, tried and tested packages is the response from the major suppliers - draw strength from being part of a 'virtual chain'. It is becoming increasingly hard to deny the apparent logic of this argument when faced with the increasing concentration in the retail pharmacy sector, where seven groups own 31 per cent of the total number of outlets (and an even higher percentage of the trade). There is a natural consequence to this: in the past, enforcing the discipline of a virtual chain on independently minded retailers has been an uphill struggle. But as the cost of 'going it alone' rises ever higher, the 'chain manager' is in a stronger position to ensure any undertakings are properly adhered to. For many community pharmacies, this could well be the price of survival.

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Lloyds hosts diabetes awareness exhibition

Asian and Afro-Caribbean communities in the Bradford area have been targeted in a diabetes awareness exhibition.

Co-ordinated by Lloyds Pharmacy, last week's two-day event at Bradford City Hall formed part of the company's year-long campaign to raise awareness of diabetes. The public were invited to a series of multi-lingual seminars and presentations covering lifestyle topics such as diet, blood glucose monitoring, exercise and healthy cooking.

Besides pharmacists, dietitians, diabetes specialist nurses, chiropodists and British Diabetic Association representatives were on hand, alongside suppliers of diagnostic meters.

Lloyds pharmacy superintendent Andy Murdock commented: "One person is newly diagnosed every five minutes in the UK and it is estimated that diabetes among Asian and Afro-Caribbean communities in particular could become two to three times more common by 2010."

PoD check course for assistants

A distance learning course on point of dispensing checks for counter assistants has been launched as part of the Department of Health's campaign to reduce prescription exemption fraud.

Every community pharmacy should have received the first part of the course last week. Questions are based on the 'Pharmacist's guide to prescription exemption', distributed to all pharmacies before the checks came into force. The second and third parts of the course should be received next week and in three weeks' time respectively.

Each part has five 'scratch card' type questions to be completed. For each set of correct answers returned, there will be prizes of T-shirts and mugs.

Boots offers clinical pharmacy services to GPs

Boots the Chemists is rolling out a new range of clinical pharmacy services for GPs.

The services are now available nationwide, following the success of a 12 month pilot in seven GP practices over four test areas. Trials showed savings to practice budgets of at least three times the rate charged for the pharmacist.

One scheme in Bangor, involving a pharmacist three days a week, which developed a clinic for patients with chronic obstructive pulmonary disease, saved the practice £15,000 on just four patients.

Services offered are those identified as being the most needed by GP practices in the trials, and include:

- a review of repeat prescribing
- implementing indicators of good prescribing practice
- developing prescribing and treatment guidelines
- participation in disease management clinics
- individual patient medication reviews.

All pharmacists providing these services have a postgraduate clinical pharmacy diploma and have received some additional in-house training relative to the scheme. Boots estimates it has 100 suitably qualified pharmacists throughout the country. Most of the pharmacists will also work in a branch local to the relevant surgery.

Charges for the services will be negotiated on an individual basis depending on which services the GPs require and how much pharmacist's time is involved. The scheme may be offered to primary care groups if there is demand.

The scheme will be promoted by regional professional development managers in their day to day workings with GP practices, and via two full-time clinical pharmacy services advisers, one based in Kent and the other in Oxford. Boots' exhibition stands at events such as the NHS Confederation conference will also be used to promote the new services.

A GP who hosted one of the trials said: "Our experience has been positive and we feel there is great potential for multidisciplinary care with relation to disease management clinics and individual patient medication review."

Review of NI practitioner fraud urged

Expenditure on pharmaceutical services in Northern Ireland needs to be reviewed. And measures should be introduced to reduce the number of prescription charge exemption claims.

The recommendations come in the Committee of Public Accounts report on fraud in the Province made to the Northern Ireland Health and Social Services Executive. The report is a result of concerns that relatively low levels of fraud were being reported in Northern Ireland compared to Great Britain, and follows on from criticisms of the Central Services Agency (CSA) by the Province's audit office (*C&D* Sep 19, p5).

The Committee is not satisfied that the 31 per cent increase in spending on pharmaceutical services to £212 million, over the three-year period to 1996-97, can be accounted for solely by increases in prescription numbers and drug prices. It recommends a review of this expenditure, and wants an explanation of the costs and reasons for differences with the rest of the UK.

It expresses concern at the difference between the 95 per cent level of exemptions claimed in 1996-7 and the 89-90 per cent level considered to be justifiable by the Executive. It recommends that the Executive introduce a timetable of measures to reduce these levels. Reducing these figures by 5 per cent would double income from statutory charges to £14m.

Electronic links between GPs, pharmacists and the CSA (*C&D* May 8, p6) are highlighted as an important method of increasing communication and reducing fraud.

The report urges the Executive to take into account the Department of Health's approach in Britain with regard to establishing a central fraud unit. It welcomes measures to introduce an anti-fraud action plan and a criminal offence for prescription fraud. Improvements in methods for calculating the extent of fraudulent exemption claims should be carried out "swiftly".

Moves to reduce patient list inflation, including the introduction of a unique patient number, were welcomed in the report. The registered patient population for the Province was 80,000 more than its published population figure.

There has been "an element of complacency" by the Executive and health and social services boards about controls over family practitioner service expenditure. This needs to be addressed, says the report.

Examples of discrepancies uncovered in the report are described below.

- No frauds were notified to the comptroller and auditor general between March 1992 and October 1997, but a significant number were notified in the period immediately following.
- A pharmacist was investigated because prescriptions submitted from his pharmacy consistently had an exemption rate of 99.9 per cent. No action was taken as, due to the prevailing security situation, the pharmacy was situated in a police 'no-go' area. It was suggested that paramilitary organisations may threaten pharmacists into not looking for exemption evidence, so that local people get their prescriptions free of charge.
- Possible overclaims of £177,000 in GPs' night visit claims were identified. Nine doctors' practices had submitted claims at a rate of more than double the Northern Ireland average.

Only 13 pharmacists co-opted to PCG boards

Pharmacists have been co-opted onto primary care group boards in 11 per cent of local pharmaceutical committee areas.

The third survey looking at PCG progress and LPC activity, conducted by Pharmaceutical Services Negotiating Committee, found that only 13 community pharmacists from nine LPCs were involved. However, further co-options are underway and have yet to be confirmed. There are 481 PCGs in England, but full board membership is not available to pharmacists. There was an 80 per cent response rate to the survey.

Despite poor representation at board level, 70 per cent of LPCs say that members are involved in PCG working groups. The main area of involvement is in prescribing, but other areas include clinical governance, strategy, health improvement programmes and primary care development. Prescribing advice is being given in over four-fifths of LPC areas.

Just over half (51 per cent) of LPCs reported that HImPs had been implemented in their area. The main national priorities are coronary heart disease/stroke and mental health, whereas the main local priorities are diabetes, asthma, the elderly, young people, oral health and sexual health.

Health action zones cover a third of LPC areas. Of these, two-thirds have LPC involvement and another two-fifths have other pharmacy involvement.

IN BRIEF

Drug alert

Ares-Serana (Eurape) Ltd is recalling Gonal-F (follitrapin alfa)150 IU pawder for salutian for injectian, batch number B3425, expiry December 2000, as the batch has an atypical stability prafile. Serana says that this represents no cancern far the safety or efficacy of the batch. The Medicines Control Agency issued the class 3 alert last Thursday. Serana can be cantacted an 01707 331972.

Scottish monthly statistics

There were 4,532,622 prescriptians dispensed in Scotland in January, 4,524,078 by chemist cantractars, at a total cost to the Exchequer af £45,040,371. Far chemist contractars, the ingredient cast per prescriptian was £8.9771, dispensing fees were £0.9509 with a professional allawance of £0.3623 and ancast af £0.0017. The grass tatal per prescriptian was £10.4209 ar £9.8090 net. The average CD fees cost per prescriptian was £0.0646.

Category D additions

Pharmaceutical Services Negatiating Committee has issued this list af additions ta Category D Part VIII af the Drug Tariff far May prescriptians: indapamide tablets 2.5mg 30s and 60s; thiaridazine tabs 50mg 100s, 100mg 100s; trifluoperazine tabs 1mg 100s, 5mg 100s; mefenamic acid capsules 250mg 500s.

Impotence treatment restrictions set out

Health secretary Frank Dobson has announced the list of selected conditions for which impotence treatments can be prescribed on the NHS from July 1.

Men with the following conditions will be eligible for NHS treatment: prostate cancer; spinal cord injury; kidney failure; diabetes; multiple sclerosis; single gene neurological disease; spina bifida; Parkinson's disease; severe pelvic injury; and men who have previously suffered from polio.

For other men who are caused severe distress by impotence, treatment will only be available in exceptional circumstances after a specialist assessment in hospital. Men receiving drugs for impotence before September 14, 1998, will also be eligible.

Amendments to Schedule 11 of the NHS (General Medical Services) Regulations will mean that prescriptions for Viagra, Caverject, Erecnos, Muse and Viridal will have to be endorsed 'SLS' by the doctor.

Mr Dobson wants to limit the number of treatments to one per week, but also wants to limit the increase in annual costs, if he can, to little more than what the NHS paid before Viagra's launch - about £12 million.

The European Transparency Directive, referred to in Mr Dobson's statement on the prescribing of impotence treatments, allows the health secretary to exclude a medicinal product or category of products from NHS supply, when the total estimated cost to the NHS "could not be justified".

This appears to give the health secretary "unprecedented" powers to prevent patients having access to medicines that they need and which have satisfied the regulatory authorities as to their safety and efficacy, according to the ABPI.

This seems to be contrary to the Government's pledges that: "The NHS will ensure that patients have proper access to the medicines they need" and "decisions about how best to use resources for patient care are best made by those who treat patients," said the ABPI. The Association is seeking an urgent meeting with Mr Dobson to clarify the position.

Pfizer's chairman, Ken Moran, has welcomed the extended range of conditions suitable for Viagra prescribing. But he believes that it is "arbitrary, unfair and discriminatory to make other sufferers obtain referral to a hospital specialist to assess whether or not they are suffering "severe distress".

"The new proposals will confuse sufferers and force GPs to discriminate amongst their patients," said Mr Moran. He added that it is illogical and costly to refer patients to consultants to assess whether they are severely distressed.

● Judgement was reserved this week in the High Court case brought by Pfizer against the Government in a bid to allow GPs to prescribe Viagra freely on the NHS. Mr Justice Collins said his decision could be expected by the end of the month.

Pfizer wants a declaration that the circular issued on September 14 advising health authorities that Viagra should not be prescribed except in "exceptional circumstances" was unlawful. If the health secretary wants to limit availability of a drug he must add it to Schedules 10 or 11 of the Drug Tariff, said David Pannick, for Pfizer.

"The secretary of state is contending for a new principle for the NHS that patients have the right to receive such drugs as their doctor prescribes, unless the secretary of state decides to impede treatment because of costs," said Mr Pannick.

Presiley Baxendale QC, for the secretary of state, said the circular was intended as interim advice only and was not financially motivated. There was concern that the pressure on GPs to prescribe would place them in a difficult position, probably resulting in postcode prescribing, she said.

Asda fuels RPM fire

Asda faces an injunction this week for price cutting on OTC medicines which are resale price maintained.

Following last Friday's announcement that the supermarket was reducing the cost of the Setlers indigestion range by 25 per cent, manufacturer Stafford-Miller (SM) threatened Asda with a High Court injunction to ensure it no longer reduced the prices.

Asda was expecting the injunction to be served by 5pm on Monday, but by Wednesday morning it was still waiting and the Setlers range was still on offer at the reduced prices.

Asda said on Monday: "There's no way we would put the price up," adding that it was pleased with the injunction delay because it was giving its customers extra days to purchase the products at the reduced rate.

SM was only alerted to the price cut by an article in last Friday's *Daily Express*. On Wednesday, the company said: "Stafford-Miller has instructed its lawyers to take all necessary steps to ensure that Asda no longer discounts the price of Setlers, in breach of contract and an injunction is being sought."

Due to legal reasons the company was unable to comment further before *C&D* went to press.

It added that over the years it has built up an excellent relationship with Asda.

The Community Pharmacy Action Group condemned Asda's "illegal and irresponsible action", saying it was surprising behaviour considering that the matter is now under consideration by the High Court.

Chairman David Sharpe said it was not in the public interest and was dictated by short-term self-interest. RPM is needed to protect "the survival of community pharmacies from the monopolistic muscle of the supermarkets.

"It's important to remember that supermarkets cannot hope to replicate the advice, support and access to healthcare services offered by 12,000 pharmacies. I hope most people would agree that saving a few pence now on a limited range of medicines is a high price to pay for the demise of up to a quarter of all pharmacies," he added.

Asked why it was necessary to price cut branded goods when they have generic equivalents, an Asda spokesman said: "More and more shoppers are using more own brands, but we want to offer people the whole choice."

Commenting on the fact that it had not been served with an injunction on Monday, the spokesman said: "We would hope and we would welcome it if Stafford-Miller decided that we could keep prices down, as it would open the doors to end price fixing."

Prior to this latest incident, Asda has faced legal action relating to over 25 products from 11 manufacturers. In 1995 five manufacturers issued letters to Asda warning that action would be taken if price cutting began.

● Asked how a pharmacy superintendent should be treated if he or she endorses a company's action, by not opposing it, which results in a breach of contract, such as breaching of resale price maintenance agreements on medicines, RPSGB head of pharmacy law Stephen Lutener said that the Society would expect a pharmacist to comply with principle three of the Code of Ethics.

This says that pharmacists must have regards to the law applicable to pharmaceutical practice. For a case to be considered, it needs to be referred to the Council, but no such case had been made to the Society, as yet. Anyone could make an initial complaint for the Society to investigate.

NHS sets deadline for applications to open walk-in pilots

The NHS wants applications for the first primary care walk-in centre pilots to be made by June 30.

Up to £30 million is available for 20 centres to be set up by March 31, 2001. Applications must be made through, or be clearly endorsed by, primary care groups and must have an endorsement by the health authority chief executive. However, desirable criteria for pilot sites include "proximity of local dispensing services with convenient opening hours" and co-location with other NHS services, including pharmacy.

Other factors will be that sites are "in a demonstrably convenient location to enable easy access by the target population, such as a town centre", and that pilots are "initiatives which make innovative use of public/private partnership initiatives".

In July, ministers will select a range of pilots and locations to test the effectiveness of a mix of service delivery configurations.

South Bucks to be a sugar-free zone

Pharmacists in South Buckinghamshire are being asked to dispense sugar-free medicine where possible as part of Smile Week.

A letter asking pharmacists to recommend, and use if possible, sugar-free medicines has been sent out. In addition, pharmacists and doctors have also been sent a poster and reminder cards to give out to patients during Smile Week which runs from May 17-23. A dental health educator has spoken to local pharmacists, who have been "very supportive", on the best way to present the information.

South Buckinghamshire is being targeted following school inspections which identified areas of highest risk.

Last chance for Harris awards

The College of Pharmacy Practice is inviting applications for the 1999 John M Harris Research and Travel Awards.

Preference is given to applications for practice research or academic work in clinical pharmacy, pharmacology or therapeutics. The top award is usually £1,500. Travel awards of up to £250 are made to assist in presenting research data at a relevant scientific conference.

The fund was initially intended to make awards for ten years and this 11th year is likely to be the last. The closing date is June 30. Further details and application forms are available from the College on 01202 692400.

Judge says FHSAA decision 'irrational'

Family doctors at a rural practice in Nottinghamshire have won a vital round in their High Court fight to stop a private pharmacy from opening in competition nearby.

The Snowden-James Group Ltd was granted 'preliminary consent' to open a pharmacy in Cropwell Bishop, south-east of Nottingham, on November 24, 1997, by the Family Health Services Appeal Authority. But 11 GPs, based at the village's surgery in Fern Road, last week won their judicial review challenge to the Appeal Authority's decision in London's High Court.

Mr Justice Latham told the court: "The decision of the Appeal Authority is, in fact, one which is flawed and must be quashed and the decision revisited." The Snowden-James Group's application to open a pharmacy will now have to be reconsidered by the Appeal Authority in light of the judge's ruling. "The doctors can obtain consent to dispense medicines to those of their patients requesting that service," said the judge.

The court heard the company was at first refused consent to open a pharmacy by Nottingham Family Health Services Authority in early 1997, but then won preliminary consent after an FHSAA hearing which took place in October of the same year.

The 11 GPs are all members of the same practice, based in the village, but operate from several different locations in the area, the court heard. The case revolved around the issue of whether there was already 'adequate provision' of pharmaceutical services to cater for the needs of the local 'neighbourhood'. Cropwell Bishop, with a population of about 2,000, has no pharmacy of its own and the nearest one is 2.8 miles away.

Mr Justice Latham said the Appeal Authority had "undoubtedly been under a misapprehension" when it granted the preliminary consent to the Snowden-James Group. The judge also ruled the Appeal Authority had failed to explain an apparent inconsistency between its decision in this case and in another similar appeal by a different applicant in 1995 - which it had rejected.

"The Authority is entitled to take a different view from time to time, but it seems to me that it can only do so rationally if it provides a reason for its change of mind," said Mr Justice Latham. "There is no reason given which I can discern from the papers before me.

"It follows that the decision, in my view, is one which can properly be characterised as irrational and that is the result of the fact that there is inadequate reasoning in respect of indications of how it could have come to the conclusion it reached."

Lawyers acting for the doctors declined to comment outside court.

Quality award for NICPPET training

The Northern Ireland Centre for Postgraduate Pharmaceutical Education and Training has been awarded ISO 9001 for its live and distance learning programmes' quality assurance system.

Terry Maguire, director of NICPPET, said: "We are now assured that the work undertaken by the Centre will be efficient and capable of addressing the training needs of pharmacists in Northern Ireland."

The Centre's quality assurance system will be reviewed every six months by external auditors to ensure compliance.

President Patel gets on HA board

Barking & Havering Health Authority has appointed pharmacist Hemant Patel to its board.

Mr Patel, president of the Royal Pharmaceutical Society, joins as a non-executive director, alongside educational consultant Joan Irwinhunt. Mr Patel has lived in the area since 1971 and is currently secretary of the Local Pharmaceutical Committee, a position he has held for five years.

Mr Patel said: "I am committed to the NHS and the contributions the various healthcare professionals can make. That is why I believe primary care groups are such an important development. It will enable GPs, nurses, pharmacists, opticians, voluntary groups and, of course, local people, to work together to develop the healthcare local people need."

GPs will lose prescribing influence

As primary care trusts (PCTs) develop, doctors will have less and less influence over prescribing choice.

Instead, it will be the clinical directors of PCTs that will have more influence on prescribing than anyone else has had in the past five years of fundholding, said Dr Howard Freeman, a GP in what is set to become the biggest PCT in the country.

The change will stem from the unified budget. As primary care groups and eventually PCTs take on responsibility for medical service costs as well as prescribing costs, cost-effective prescribing will become more important. But with influences such as clinical governance, formularies and the clinical directors, GPs will lose even more individual prescribing choice.

Dr Freeman was part of a panel organised by the Pharmaceutical Marketing Society debating the question 'Prescribing in the new NHS - who is making the decisions?'. Kevin Guinness, head of the pharmacy and prescribing at the Department of Health, said that the GP has the responsibility to prescribe what was needed for their patients and "that's not going to change in the new arrangements".

The purpose of having a unified budget is to have a more level playing field to enable a balance between expenditure with medicines and other areas of care.

Another influence, the National Institute for Clinical Excellence, will offer guidance, "and guidance it will be", said Mr Guinness. However, he added: "It would be wrong to rule out entirely the prospect of ministers from time to time wanting to use the limited list."

Principal primary care pharmacist with Central Croydon Commissioning Group, Mark Robinson, added that although the GP is still making the prescribing decisions, a corporate ethos is developing, which will be a change for doctors. Primary care prescribing managers will have to work with their counterparts in secondary care to iron out the differences between the two and there will need to be a release of information across the interface, he said.

Dr Mark Charney, director of the National Centre for Clinical Audit, said that the changes were part of a worldwide move towards evidence-based healthcare. However, he was concerned that the move would not eliminate poor quality care. "Evidence-based care is not all it's cracked up to be as the evidence base is very flawed," he said. It may be fine in the abstract, but may not work when applied to large scale human models.

Pictured at the Pharmaceutical Marketing Society's question time: NCCA director Dr Mark Charney, BMA Council member Dr Howard Freeman, John Davis (Springboard Consultancy), pharmacist Mark Robinson and the DoH's Kevin Guinness

GP PERSPECTIVE

Open all hours

One thing you cannot accuse the Government of is neglecting primary care. In among all the other changes to the NHS, the Prime Minister sprung another surprise recently by announcing the creation of 20 walk-in primary care centres up and down the country.

These will be open well beyond the standard hours offered by doctors' surgeries and it is likely they will be placed in areas of high population density. This idea copies other service industries which now offer their wares around the clock.

The proposal sounds interesting: it could relieve pressure on hard-pressed out-of-hours services and A&E departments. It would offer the public a service at more convenient times of the day. The Government will, of course, take the credit for this bold initiative to expand NHS care.

"GPs should become involved without fear of eroding their status"

But behind the headlines, there is a lack of detail. How will these centres liaise with the patient's GP? An expansion of this service could increase patient expectations and, as a result, the service could be swamped. There is also unease that such centres could undermine the GP's place as a first point of contact for NHS healthcare.

GPs will be eagerly watching developments. It is unlikely that they will oppose them: they would not want to be seen standing in the way of progress. GPs will probably become involved in these centres anyway, probably through primary care groups and out-of-hours deputising services.

NHS Direct is also growing. As this service expands, it is again challenging the GP's role as a gatekeeper to healthcare. NHS Direct will offer patients health information and advice: its role is likely to evolve and expand.

Many GPs may feel that these fast moving developments threaten to marginalise them. Many want to jump on the bandwagon and protect their status. However, there is no need to be so wary of these new ideas. GPs will still be needed. These initiatives may, in fact, generate more work for primary care, or they may not succeed.

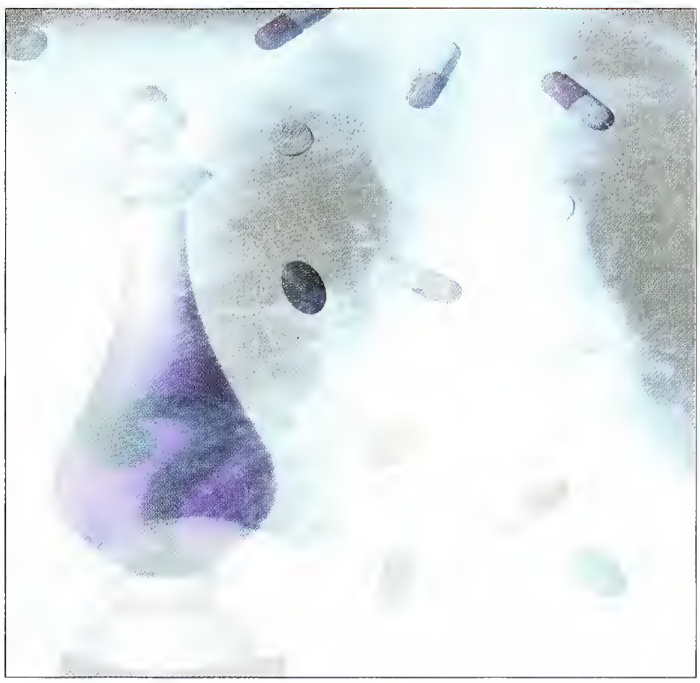
Either way, they will not replace GPs. GPs should become involved without fear of eroding their status.

By Dr Harry Brown, a GP practising in Seacroft, Leeds

Xrayser

Topical Reflections

The worts and all of herbal medicine



Herbal medicine is a growing part of my business, but most sales are fuelled by hearsay information on a product's efficacy. And consumers tend to take the view that, even if they do not work, because they are natural at least they are safe!

The dominant regulatory control is safety because to obtain a medicines licence to demonstrate efficacy involves research costs that few companies can afford, for products where patent protection is almost impossible to achieve.

This is a problem highlighted a few weeks ago by an excellent article in *The Guardian* (April 13). But it was brought to my attention again this week by a visit from the Seven Seas rep, who suggested I stock the company's Höfels brand One-a-day St John's Wort capsules.

I already stock a number of competing St John's Wort products and they sell well, despite being unlicensed in this country. Nevertheless, my curiosity was aroused, so I compared three of my existing brands with this new competitor.

Among the four products, the suggested daily dose ranged from 900mcg to 4,500mcg of the active principle, hypericin, but none provided any guidance of effect.

By no stretch of the imagination can St John's Wort be considered a food supplement. I know from talking to customers that most take the herb as an alternative to using medically prescribed antidepressants and it is licensed for this purpose in some European countries at doses of around 3,000mcg per day.

When asked, I recommend the higher dose ranges, and have received very positive feedback from a number of satisfied customers, but I have to be very careful in my recommendations because I am unsure of my legal position in knowingly allowing a 'food supplement' to be sold to treat a 'medical' condition.

Höfels One-a-day allows no flexibility in dosage and would not be my preferred recommendation, but 'One-a-day' is a good selling point and all Seven Seas One-a-day lines are popular with my customers. I am sure its St John's Wort will be no exception and I have already placed it alongside its competitors.

But it would be much better for the consumer if the product's licensed indications were clearly shown, with dosage instructions obtained from properly researched information.

Student's debt burden needs looking at

The Branch Representatives Meeting of the Royal Pharmaceutical Society comes around with monotonous regularity, and having read the list of motions to be debated in the morning session, the word 'monotonous' seems particularly appropriate.

Many motions appear designed to publicise the name of a branch rather than to stimulate serious debate, but of those that caught my eye, one from the British Pharmaceutical Students' Association is worthy of serious consideration.

To some the financial problems of students may not seem a relevant subject when taken in the context of the profound changes that political decisions are causing within the profession. But today's student is tomorrow's professional colleague and having dealt with many pre-registration students, I know that the financial pressures they face are increasing.

Last year the four-year course came into existence and the Government introduced a charge to each student of £1,000 per annum for course fees, while keeping the maintenance grant frozen at prehistoric levels.

The net effect is that more and more students are entering the profession with increasingly large burdens of debt which they then have to repay from their first years of full-time employment.

A mere £100 may seem insignificant to many branch representatives, but to many students it is another financial millstone around their necks which, this time, has been imposed by their own professional Society.

I would not only fully support this motion and cancel the £100 registration examination fee, but would suggest that the question of registration fees for those passing the examination should also be debated.

At the moment, assuming they register in July, it costs a newly registered pharmacist the full £134 for only six months registration. This, on top of their other costs, appears an unreasonable burden.

I would suggest an amendment to the motion from the floor which either proposed that all newly registered pharmacists should not be liable to any fees until the following January or at least that a *pro rata* fee structure be introduced.

Script specials

Tanatril – a long-acting ACE inhibitor

Tanatril (imidapril) is a new long-acting angiotensin converting enzyme inhibitor from Trinity Pharmaceuticals.

Imidapril is mainly hydrolysed to its pharmacologically active metabolite, imidaprilat, producing a potent and long-acting hypotensive effect. Maximum plasma concentrations are reached within seven hours.

Excretion is predominantly via the kidney, so renal function should be evaluated before starting treatment.

Treatment should be initiated at 5mg once daily, which can be increased to 10mg after three weeks if optimum blood pressure control has not been achieved. The maximum dose of 20mg daily may be needed in some cases, preferably in combination therapy with a diuretic.

In the elderly the initial dose is 2.5mg daily, and the maximum is 10mg once daily. Doses should be taken at the same time each day about 15 minutes before meals.

Tanatril comes in two strength tablets: 5mg (28, £5.92) and 10mg (28, £6.69).

Trinity Pharmaceuticals Ltd.
Tel: 01484 604506.

Flixotide seeks licence for use in COPD

Glaxo Wellcome is seeking European regulatory approval to market the inhaled corticosteroid Flixotide (fluticasone) for the symptomatic treatment of chronic obstructive pulmonary disease (COPD).

The application is supported by data from the ISOLDE study (Inhaled Steroids in Obstructive Lung Disease in Europe) which showed Flixotide to have beneficial effects on lung function, with reduced exacerbation rates and reduced rates of decline in quality of life over a three year period.

Another large placebo-controlled study, published last year, showed that patients treated with Flixotide over a six month period had significantly improved lung function, symptoms and severity of exacerbation compared to patients treated with existing bronchodilator therapy.

COPD is the third most common cause of death in the European Union, after cancer and heart disease.

Glaxo Wellcome UK Ltd.
Tel: 0181 990 9444.

MEDICAL MATTERS

'Independent' GP education package improves menorrhagia care

A GP education package developed by academics in Cambridge has been shown to improve management of menorrhagia in primary care.

A study, published in the *British Medical Journal*, found that detailing by independent academics in small, practice-based interactive meetings, led to more appropriate treatment for women with menorrhagia (regular, heavy periods) and less unnecessary referral to secondary care.

Some 100 practices in East Anglia (348 doctors) were recruited and randomised to the education package (54) or to a control group (46).

Practices in the intervention group were visited by the academics and presented with visuals, a printed evidence-based summary and a graphic management flow chart. They were then visited again six months later.

All practices had to record consultation details, treatments offered and outcomes for women with menorrhagia over one year.

The number of consultation data sheets returned was 1,001. These showed significantly fewer referrals with the 'educated' group compared to control (20 per cent *vs* 29 per cent) and a significantly higher use of tranexamic acid in the intervention group, but no overall difference in norethisterone treatment.

There were also more referrals when tranexamic acid was given with the hormone than when it was given alone. Practices with fewer than ten cases showed the highest increase in prescribing of tranexamic acid.

The authors say there is a reluctance to prescribe tranexamic acid, possibly because of poor awareness of the drug's role. Although it is the most effective first line treatment, in one survey only 4.5 per cent of patients received it. The education package attempted to 'demystify' the drug by emphasising the low risk of antifibrinolytics and by encouraging its use as a first line therapy.

A package like the one used can positively influence prescribing and referral of women with menorrhagia. The implications of this are considerable. Lower referral rates could bring down the number of surgical procedures – 60 per cent of referred women will have a hysterectomy.

WHO calls for stricter regulation on nicotine

Cigarettes and the tobacco industry should be governed by the same sales and promotion regulations that apply to nicotine replacement products and pharmaceutical industry.

The World Health Organization is now calling on international food and drug regulators to instigate these changes.

Dr Gro Harlem Brundtland, director general of WHO, said a cigarette should be judged for what it is, and not for what the tobacco industry makes it out to be.

This is the first time WHO has called on food and drug regulators to rationalise the rules that govern all forms of nicotine consumption.

Dr Brundtland, speaking at the International Conference of Drug Regulatory Authorities in Berlin, said tobacco control experts find it inconsistent that harmful nicotine from cigarettes is available freely while nicotine replacement products come under the jurisdiction of the doctor or pharmacist.

World No-Tobacco Day is on May 31.

IN BRIEF

Meningitis vaccine submission

Wyeth Lederle Vaccines has applied for a UK licence for its new meningococcal C conjugate vaccine for the prevention of meningococcal systemic type C disease. Clinical studies have shown vaccine to be highly immunogenic and effective in infants as young as two months. Current polysaccharide versions have shown differences in immunity particularly in younger children.

Brexidol with fast-acting carrier

Brexidol is a new formulation of piroxicam which includes an inert carrier, beta-cycladextrin, for faster dissolution (100 per cent in ten minutes) and drug uptake. Brexidol has the same indications as piroxicam. The recommended dose is one tablet (equivalent to 20mg piroxicam) daily; this may need to be halved in the elderly. The basic NHS price of 30 tablets is £12.80.

Trinity Pharmaceuticals. Tel: 01484 604506.

Keral uses ketoprofen isomer

Keral has been formulated using only the S(+) isomer of the NSAID ketaprafen in an attempt to reduce side effects, while retaining the compound's analgesic and anti-inflammatory qualities. The new formulation is also a highly soluble trometamol salt which means rapid absorption from the gut and faster relief of symptoms. Keral (dexketaprafen 25mg) is indicated for mild to moderate pain. The dose is one tablet every eight hours, or half a tablet every 4-6 hours.

A Menarini Pharmaceuticals. Tel: 01189 730013.

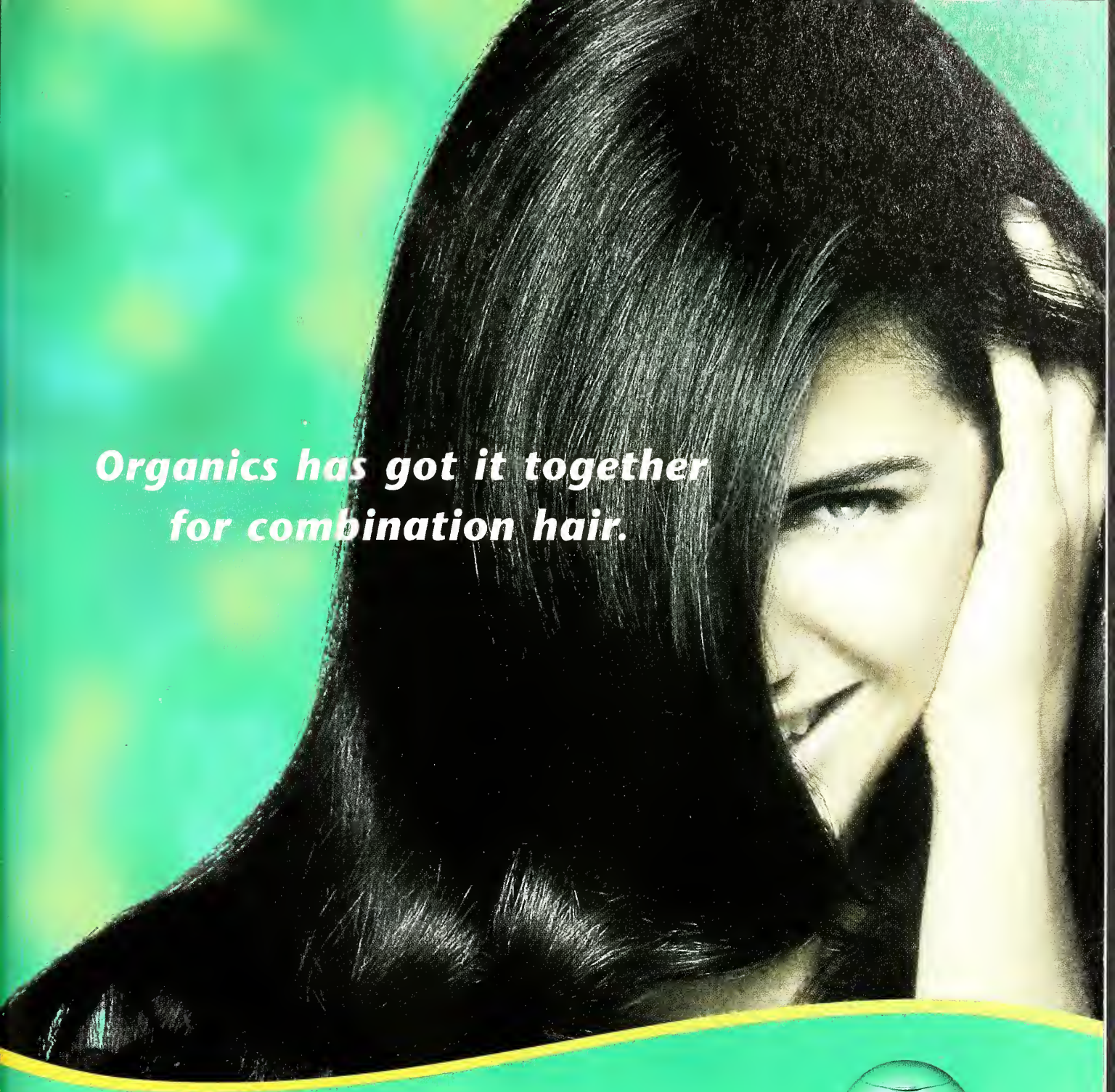
Nutricomp ACBS-approved

Nutricomp Standard and Nutricomp Standard+Fibre enteral feeds (200ml, basic NHS price £1.33; 500ml, £2.68) have received ACBS approval. Both products are being supplied in bottles and nutribags.

B Braun Medical. Tel: 01296 393900.

Lactugal transfer

Intropharm has taken over the marketing and distribution of Lactugal (lactulose solution) from Galen. A 500ml presentation will be launched in June. All orders should now be placed with Intraphorm's distributor: Forillan Ltd. Tel: 01708 379000.



Organics has got it together for combination hair.

Greasy roots, dry tips - it's the classic 'combination hair' problem for up to 21% of your customers.

Now Organics has the perfect answer: a new shampoo with a real breakthrough formulation.

New Organics Combination Hair shampoo is the first dual-action hair product on the market with nutrients replenishing dry tips, whilst controlling agents prevent greasiness at the roots.

Organics will be spending a massive £9 million (MMS) supporting the brand including £2 million on the new Combination variant - TV advertising commences 1st May.

This unmet need in the market will be big news, so stock up generously and let Organics revitalise your sales.

ORGANICS

ELIDA FABERGÉ
LONDON

Counterpoints

Fruity additions for Dioralyte Relief

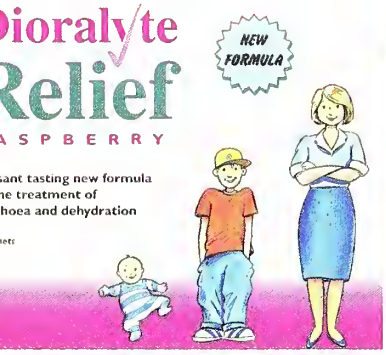
Rhône-Poulenc Rorer is extending its Dioralyte Relief oral rehydration range with the launch of new raspberry and blackcurrant flavours.

A colourful new pack design featuring cartoon characters has also been introduced for the range. Consumer research by the company shows that children prefer the taste of the raspberry and blackcurrant flavours to the brand's original flavour.

Formulated to relieve the dehydration that can result from diarrhoea, the products replace body fluids and replenish essential electrolytes.

Retail price is £3.40 for six sachets.

Rhône-Poulenc Rorer Ltd.
Tel: 01732 584000.



Vitabiotics helps build calcium supplement sales

Vitabiotics will be promoting its Osteocare calcium supplement in June to coincide with National Osteoporosis Month.

Osteocare will be supported by an advertising campaign in women's magazines and general interest titles with the message: 'Important news if you are thinking of taking calcium'.

The brand will also be sponsoring the 'Two minute clinic' on national radio from June 7, and radio commercials on LBC and News Direct on May 17.

It will also be supported by posters on the London Underground and postcards in gyms and health clubs.

Vitabiotics Ltd.
Tel: 0181 902 4455.

A cool preparation

Preparation H haemorrhoid treatment now comes as a cooling gel containing witch hazel.

Preparation H Clear Gel will complement the existing range of ointment and suppositories and will retail at £2.99 for a 25g tube.

New packaging has been used for the gel and this will be extended to the rest of the range in the summer.

A £350,000 advertising campaign in the national press, women's magazines and pregnancy titles is planned for the gel from June.

Pharmacy counter assistant training will follow later this year.

Whitehall Laboratories Ltd. Tel: 01628 669011.

A female face for Solpadeine campaign

SmithKline Beecham Consumer Healthcare is supporting its Solpadeine Pharmacy-only painkiller with a new £1 million regional TV campaign.

The campaign features the original computer generated, male character in an ad focusing on headaches, as well as a female counterpart in a new commercial that emphasises the suitability of Solpadeine for back, muscle and joint pain.

The campaign will be seen in the South, North-west, West Country, Yorks, North-east and Wales until the end of May.

It coincides with the launch of SB's annual window display competition for Solpadeine. The closing date for the competition is May 31.

SmithKline Beecham Consumer Healthcare.
Tel: 0181 560 5151.

TCP is all set for summer

Pfizer Consumer Healthcare is running a summer campaign highlighting its TCP antiseptic brand's efficacy as a first aid treatment.

Aimed at mums with young families, the campaign focuses on a small, mischievous cartoon child with a grazed knee, either sitting on a gate or a swing.

In-store display material features cartoon bugs, and pharmacies will receive furry bees, either to use in-store or to give to customers.

PoS material includes a window display, shelf edger and counter display unit which holds TCP Antiseptic Liquid, Cream and Ointment.

Pfizer Consumer Healthcare.
Tel: 01420 84801.

'I'm not sure why I have diarrhoea'

Johnson & Johnson MSD is launching its latest pharmacy education initiative for Imodium this week.

With the theme 'I'm not sure why I have diarrhoea', the new campaign aims to develop in-pharmacy knowledge of diarrhoea and its causes.

It is also designed to build confidence in anti-diarrhoeal recommendation by defining the specific benefits of each of the three Imodium products – Imodium capsules, Imodium liquid and the loperamide/simethicone combination Imodium Plus chewable tablets.

Campaign materials include a consumer leaflet counter and shelf units plus a recommendation reminder card.

Also available are a giant Imodium display pack, IBS leaflet, a 'Performance Anxiety Diarrhoea' leaflet, and an 'Understanding Diarrhoea' booklet.

The pharmacy 'I'm here to help' pack is designed to make the dialogue with the consumer easier and reduce embarrassment.

Johnson & Johnson MSD Consumer Pharmaceuticals.
Tel: 01494 533694.

POSITIVE SIGNS FOR PROPAIN®

- **Consumer TV and Press promotions have almost doubled awareness of Propain® amongst consumers[1].**
- **Propain® is growing at more than double the market rate[2].**

97% of migraine sufferers who have tried Propain® are likely to repurchase the brand[3].

Contains: paracetamol, codeine phosphate, diphenhydramine hydrochloride, caffeine

References: 1. Taylor Nelson Quarter 3 1998 **2.** IMS Dataview. January 1999 **3.** Propain Spotlight Study. Taylor Nelson Sofres Healthcare. November 1998.
PROPAIN TABLETS ABBREVIATED PRODUCT INFORMATION Presentation: Yellow compressed tablets with a scored bisect line on one side, each containing: paracetamol BP 400mg; codeine phosphate BP 10mg; diphenhydramine hydrochloride BP 5mg; caffeine BP 50mg. **Indications:** Treatment of migraine, headache, muscular pain, period pain and toothache. Also for the symptomatic relief of influenza, feverishness and colds. **Dosage:** Adults, the elderly and children over 12 years of age: 1 to 2 tablets every four hours up to a maximum of 10 tablets in 24 hours. **Contra-indications:** Propain is contra-indicated in patients with known hepatic or renal impairment and during pregnancy or lactation. **Warnings:** Propain may cause drowsiness and affected individuals should not drive or operate machinery. Immediate medical advice should be sought in the event of an overdose, even if you feel well, because of risk of delayed, serious liver damage. **Precautions:** The effect of alcohol and other sedatives may be potentiated. Excessive intake of caffeine-containing drinks should be avoided. **Legal Category:** P. **Pack Details:** Propain tablets (PL 0542/0015R): **Trade prices:** 12 tablets £1.31 (R.S.P £2.30), 24 tablets £2.25 (R.S.P £3.95). **Product Licence Holder:** Farillan Ltd, Romford RM3 8UE. Full product information is available from: Sankyo Pharma UK Limited, Reptan Place, Amersham HP7 9LP. **Date of preparation:** March 1999. PF9901T

SANKYO PHARMA UK Limited

SB launches strawberry gel for milk teeth

SmithKline Beecham is introducing a new flavoured gel for milk teeth in its Macleans range.

Macleans Milk Teeth is a strawberry flavoured, sugar-free, low fluoride gel. The product has British Dental Association (BDA) accreditation.

The launch will be supported by a £150,000 campaign in the parenting press from July to December, as well as involvement in the Bounty programme (which creates awareness among young mothers), nursery education packs and couponing through Health Education Authorities.

Retail price is £1.19 (50ml tube).

The children's toothpaste market is growing at 6.5 per cent year on year and gel is the fastest growing segment.

SmithKline Beecham Consumer Healthcare UK.
Tel: 0181 560 5151.

New look for animal friendly cosmetics

Fine Fragrances & Cosmetics has relaunched the Beauty Without Cruelty colour cosmetics range which it acquired last year.

Designed to appeal to women of all ages, the cosmetics are presented in new royal blue packaging, featuring a gold swan brand logo.

The brand philosophy means that there is no animal testing on finished products or ingredients. The cosmetics are also free from animal derived ingredients and the range is suitable for vegetarians.

The collection features Moisturising Lipstick, Superfine Powder Blusher, Glow Bronzing Powder and Silk Finish Eye Shadow in solo and duo compacts.

Foundations come in Matt Finish Liquid Make up, Silk Finish Cream Make up or Natural Look Tinted Moisturiser.

The range also includes concealer, loose or pressed powders, eye pencils, mascara and nail colour.

Retail prices range from £2.25 for the Soft Kohl Eye Pencil to £4.95 for 25g Ultra Fine Loose Powder.

An attractive display stand is available for in-store use.

An advertising and promotional support programme is planned for next autumn/winter.

Fine Fragrances & Cosmetics Ltd.
Tel: 0181 979 8156.

Psst ... Nivea Sun is on TV

Beiersdorf is supporting its new Nivea Sun Spray with a humorous TV campaign until mid-July.

Targeted at younger consumers and 18-30-year-old men, the new commercials focus on the spray's ease and convenience of use.

The campaign features four completely different versions of a beach scene where people are taken off guard by the 'psst psst' noise of the spray action.

Amusing scenarios include a woman being whisked off by a kite, a man being hit full force by a low flying frisbee and 'Mr Average' exposing himself when his towel drops to his ankles.

Beiersdorf UK Ltd.
Tel: 01908 211444.

Astral gets rich with new campaign

Dendron is backing its Astral moisturising cream with a national newspaper advertising campaign in May and June.

The brand message in this distinctive blue and white advertising campaign is 'For the beauty you so richly deserve'.

Aimed at women aged 25 and above, the campaign follows the recent relaunch of the brand.

A major sampling programme for Astral starts this month and will run until December.

A wallet containing a mini-tube of the product and a £0.50 off purchase coupon will be dropped through the letter boxes of over 150,000 women. There will also be sampling at roadshows, exhibitions and clubs.

Dendron Ltd.
Tel: 01923 229251.

Olay ... it's talking mascara

Procter & Gamble will be introducing two new mascaras in its Olay Colour range in June.

'Talking Mascara' is designed to widen the eyes by giving lashes long lasting body and lift. It is available in 'Subtle' for a natural look and 'Striking' for a more defined, dramatic look.

The mascaras come in two shades - black and black brown. Suitable for use with contact lenses, the products are formulated to be hypo-allergenic and smudgeproof.

Retail price is £6.99. A special introductory price of £5.49 will be available at selected stores while stocks last during June and July.

Procter & Gamble UK.
Tel: 01932 896000.

Pearl Drops aims to be part of a girl's beauty routine

Carter Wallace is supporting its Pearl Drops whitening toothpolish with a new TV campaign running throughout the summer.

Aimed at women aged 16-24 years, the commercial suggests that Pearl Drops should be an essential part of every girl's daily beauty routine. This is summed up with the closing strapline: 'Pearl Drops Toothpolish - beauty treatment for teeth.'

The campaign will run continuously for five months in all regions on Channel 4, Satellite and Channel 5, with prime time slots on ITV and GMTV during June and August.

Carter Wallace Ltd.
Tel: 01303 850661.

Anti-ageing hand cream for Fenjal

Chemist Brokers is introducing a new anti-ageing hand cream in its Fenjal Beauty Spa range.

Age-Defying Hand Creme is a light and non-greasy cream formulated to form a moisturising barrier on the skin.

Ingredients include vitamin E to protect against free radical damage and D-panthenol to moisturise and smooth fine lines.

The product is claimed to increase the skin's moisture content by over 30 per cent and to reduce wrinkle depth after four weeks' daily use.

It is suitable for all skin types. Retail price is £3.25 for 75ml.

The launch will be supported by promotions and a sampling campaign.

Chemist Brokers Ltd.
Tel: 01705 222500.

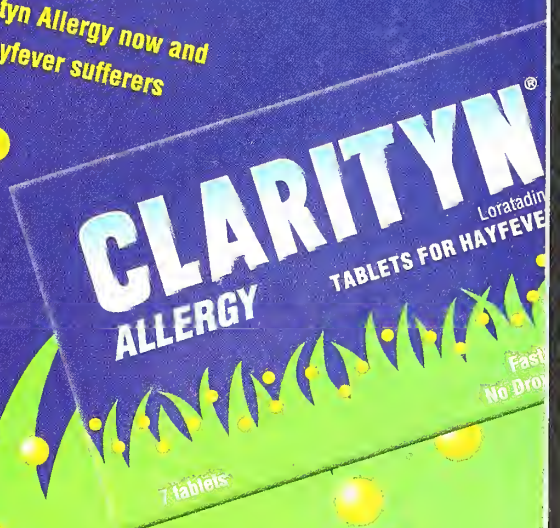
DON'T LET HAYFEVER THREATEN THEIR SUMMER

New TV commercial. National coverage!

The efficacy of Clarityn Allergy is unsurpassed. And to drive customers through your door there's a new TV commercial which will appear on National TV – including regular mid-break slots on Channel 4's *'Friends'*. Plus there's a nationwide PharmaSite poster campaign and sponsorship on commercial radio during National Allergy Week.

For impact in-store, we've designed a window display featuring the moving 'pollen storm' from the TV ad, together with window friezes, a counter display, dummy packs, pens and bags.

So stock up on Clarityn Allergy now and make sure that your hayfever sufferers have a great summer.



Clarityn Allergy prescribing information: Clarityn Allergy Tablets contain 10mg loratadine. Clarityn Allergy Syrup contains 5mg loratadine per 5ml. **Indications:** *Adults and children aged 12 and over:* For the relief of symptoms associated with seasonal & perennial allergic rhinitis and idiopathic chronic urticaria. *Children aged 2 to 12 years:* For the symptomatic treatment of hayfever and allergic skin conditions, such as urticaria. **Dosage:** *Adults and children aged 12 and over:* One tablet once daily or two 5ml spoons of syrup once daily. *Children aged 6 to 12 years:* Two 5ml spoons of syrup once daily. *Children aged 2 to 5 years:* One 5ml spoon of syrup once daily. **Contra-indications, precautions:** Hypersensitivity. Pregnancy and lactation. Use in children under 2 years. **Side-effects:** Rarely fatigue, nausea, headache, [illegible] anaphylaxis, abnormal hepatic function, supraventricular tachyarrhythmias, tachycardia and syncope have also been reported rarely although causal relationship has not been established. Concomitant administration of drugs which inhibit P450 3A4 and 2D6 metabolic pathways may result in elevated plasma levels of loratadine or the concomitant medication. **Pack sizes:** Cartons of 7 tablets. Bottles of 90ml syrup. **Retail price:** Tablets £4.25, syrup £6.99. **Legal category:** P. **Product licence numbers:** Tablets 0201/0175. Syrup 0201/0173. **Product licence holder:** Schering-Plough Ltd., Shire Park, Welwyn Garden City, Hertfordshire AL7 1TW. **Date of revision:** August 199[illegible]

SCHERING-PLOUGH CONSUMER HEALTH

Cannon keeps abreast of baby feeding accessories

Cannon Rubber is relaunching its Avent range of breast-feeding accessories in new co-ordinated packaging.

The new look range features the Avent ISIS Breast Pump which has been designated a millennium product for 'making a significant difference to women's lives'. The pump is available with a 4oz bottle or the Avent Disposable.

The line-up also includes a 'back to work' breast pump set, a breast milk travel pack, a breast milk storage kit, breast milk and baby food containers, disposable breast pads, washable breast pads, nipple shields and the Niplette, which offers non-surgical permanent correction of inverted or flat nipples.

Retail prices range from £3.29 to £45.

Cannon Rubber Ltd.
Tel: 01787 267000.

Playtex system targets breast-feeding mums

Clarrell International is the new UK distributor for the Playtex Disposable Nurser System.

The company aims to widen the availability of this American infant feeding system primarily targeted at breast-feeding mothers.

The Playtex Nurser System comprises a 'bottomless' bottle into which Playtex pre-sterilised, collapsible liners are placed. Air can then be pushed out of the liner from the bottom to help eliminate colic.

New to the range is the Eazy Feed system which features pre-formed drop-in liners for easy preparation of babies' feeds.

Both systems use Playtex teats designed to be similar to a mother's nipple in terms of shape, size and elasticity. The teats elongate to mimic a mother's nipple and deposit fluid on to the back of the tongue which aids digestion.

The teat range comprises an infant nipple (newborn to six months), older baby nipple (over six months), orthodontic and flat top or round top silicone nipples.

Retail prices range from £1.99 for a pack of two teats to £4.99 for the Eazy Feed system. A box of 50 pre-formed liners also retails at £4.99.

Clarrell International Ltd.
Tel: 01634 717771.

ColourCare keeps customers in the picture

ColourCare will be offering a free Photo Index to every customer ordering 7in x 5in developing and printing this summer.

The peak period summer season promotion is designed to stimulate sales of 'regular' size 7in x 5in processing and increase awareness of Photo Index among 35mm customers.

The promotion is scheduled to run from May 24 to July 30.

ColourCare International Ltd.
Tel: 01722 412202.

Wilkinson Sword sharpens razor sales

Wilkinson Sword is backing its Protector 3D Razor with a new £1.5 million TV campaign.

Targeted at 16-34-year-old men, the four week burst breaks on May 15.

The brand is also being supported by in-store promotions running at the same time as the TV campaign.

Wilkinson Sword Ltd.
Tel: 01670 713421.

Feet first for summer campaign

Seton Scholl Healthcare is launching a £2 million campaign in the women's and men's press between May and September. Products highlighted will include Rough Skin Remover, Deep Moisturiser and Odour Control.

Seton Scholl Healthcare plc.
Tel: 0161 654 3000.

IN BRIEF

Kodak offer

Kodak is launching a new promotion that will run from June 14 until the end of September. Consumers ordering Kodak Photo Service Plus or Kodak Advanced Photos during the promotional period will receive a voucher with their returned prints entitling them to £1 off a roll of any type of Kodak film.

Kodak Ltd.
Tel: 01442 261122.

Smile please

The British Dental Health Foundation is launching National Smile Week (May 17-24) to increase public awareness of the benefits of dental health. National Smile Week is being promoted nationwide on TV, radio and in the national and local press.

British Dental Health Foundation.
Tel: 01788 546365.

Don't be bugged by athlete's foot

Johnson & Johnson MSD Consumer Pharmaceuticals is supporting its Daktarin athlete's foot treatment during National Foot Health Week (June 5-12).

The campaign will feature a series of activities to inform and educate the public about athlete's foot.

The company will be offering free foot 'MOT checks' at MediCentres in London at key commuting times. Sports centres will also be targeted with a poster campaign which gives basic advice on how to treat and avoid athlete's foot.

Pharmacy materials include symptom specifier cards and leaflets.

Johnson & Johnson MSD Consumer Pharmaceuticals.
Tel: 01494 450778.

ON TV NEXT WEEK

Arrid XX: All areas except U, CTV

Beconase Allergy: C4, C5, Sat

Benadryl Allergy Relief: All areas

Clarityn Allergy: C4, C5, GMTV, Sat

Deep Relief: C4, C5

Imodium Plus: All areas

Kwai Garlic: G, Y, HTV, M, TT

Listerine antiseptic mouthwash: All areas

Livostin Direct: B, G, Y, C, A, HTV, W, M, LWT, TT

Pearl Drops toothpolish: All areas except U, CTV

Rhinolast Hayfever: C4, C5, Sat

Vitalegs Herbal Gel: B, G

Zi: C4, Sat

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

THIS SUMMER, YOUR CUSTOMERS
CAN BE REALLY BRAVE.
THEY CAN SIT IN THE GARDEN.

Zirtek
ALLERGY cetirizine

MAKES LIGHT OF HAYFEVER

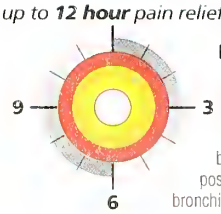
ZIRTEK ALLERGY
PRESENTATIONS: White, oblong, scored, film-coated tablet engraved Y/Y containing 10mg cetirizine hydrochloride.
USES: Treatment of seasonal and perennial rhinitis and chronic idiopathic urticaria.
DOSAGE AND ADMINISTRATION: Adults and children aged 12 years and over: 10 mg once daily. In renal insufficiency halve the dose to 5 mg (½ tablet) daily.
CONTRAINDICATIONS: Hypersensitivity to constituents. Avoid use in pregnancy and lactation. **PRECAUTIONS:** Do not exceed recommended dose, particularly if driving or operating machinery.
DRUG INTERACTIONS: To date there are no known interactions with other drugs. As with other antihistamines avoid excessive alcohol consumption.
SIDE EFFECTS: Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort have been reported.
PACKING, PRICE: Pack of 7 tablets = £4.25.
LEGAL CATEGORY: P
PRODUCT LICENCE NUMBER: Tablets 5221/0001.
MARKETED BY: UCB Pharma Limited, Watford, Herts, WD1 1DJ

Date of preparation: December 1998
UCB-Z-99-05

ucb Pharma

All the way to Hong Kong on one

up to ***12 hour*** *pain relief*



PRODUCT INFORMATION FOR NUROFEN LONG LASTING. Nurofen Long Lasting: Each capsule contains 300mg ibuprofen. **Indications:** For the effective relief of backac dysmenorrhoea, migraine, headache, dental pain, non serious arthritic and rheumatic pain, neuralgia, and muscular pains. **Dosage:** Adults, elderly and children over 12 years: One or t capsules taken twice daily. The capsules should be taken together with water and swallowed whole. Do not chew or suck the capsules. Do not take more than 4 capsules in 24 hours. Th should be at least 8 hours between doses. Not suitable for children under 12 years of age. If symptoms persist consult your doctor. For oral administration. **Precautions and Warnin** Patients with existing, or a history of peptic ulceration, hypersensitivity to any of the constituents, aspirin or other non-steroidal antiinflammatory drugs (NSAIDs). Patients with a history bronchospasm, rhinitis, urticaria, associated with aspirin or other NSAIDs. Caution is required in patients with renal, cardiac or hepatic impairment. In these patients, the dose should be as low possible and renal function should be monitored since it may deteriorate following the use of any NSAID. Bronchospasm may be precipitated in patients suffering from, or with a previous history bronchial asthma or allergic disease. The elderly are at increased risk of the serious consequences of adverse reactions. Undesirable effects may be minimised by using the minimum effective dose

dose of Nurofen Long Lasting

Backache is a very common problem, even more so in old age. But staying free of pain the whole day is something everyone is entitled to.

Just one convenient dose of Nurofen Long Lasting can ease pain for up to 12 hours.[1] Two capsules of the sustained release formulation provide a delivery of 600mg of ibuprofen, giving long-lasting relief for up to 12 hours.[2]

Nurofen Long Lasting can help sufferers of backaches, non-serious arthritic pains and other muscle and joint pains get on with their lives without the need for frequent re-dosing.[2] Why not let your customers benefit from pain relief for up to 12 hours on just one dose of Nurofen Long Lasting?

new

Designed to **keep going**

the shortest possible duration. **Side effects:** *Gastrointestinal:* Abdominal pain, nausea and dyspepsia. Occasionally peptic ulcer and gastrointestinal bleeding. *Skin:* Pruritis, urticaria and rash. Rarely exfoliative dermatitis and epidermal necrolysis have been reported with ibuprofen. *Renal:* Papillary necrosis which can lead to renal failure. *Others:* Rarely hepatic dysfunction, headache, dizziness, hearing disturbance and thrombocytopenia. Bronchospasm may be precipitated in patients with a history of aspirin-sensitive asthma. **Product licence Number:** PL 00327/0101. **Licence Holder:** Crookes Healthcare Limited, Nottingham NG2 3AA. **Legal category:** P. **Price:** 12's £2.69, 24's £4.99. **Date:** March 1999. **References.** 1. Nurofen Long Lasting Summary of Product Characteristics. 2. Data on File, Boots Healthcare International, Study 1.

CROOKES HEALTHCARE

ibuprofen

The Specialist

Jonathan Fawdry, a director of Eldon Laboratories, believes the company's success is based on three things – "service, service, and service". He explains what sets Eldon apart from other specials manufacturing companies...

Jonathan Fawdry, a director of Eldon Laboratories

Good service is so widespread today that it is often taken for granted. But Jonathan Fawdry, newly appointed director of specials manufacturer Eldon Laboratories, believes it is what sets his company apart from the competition.

Mr Fawdry believes the rapid growth of this Newcastle based company suggests that, previously, specials manufacturing was "probably not delivered as well as it should have been". With a turnover of £2 million - a 13-fold increase on four years ago, the UniChem subsidiary now has a 25 per cent share of the manufacturers' dispensing specials market.

Eldon was set up in 1989 and its main customer is "the switched on pharmacist" - those who know that they have to guarantee the quality of their medicines but often do not have the time to prepare products themselves.

To guarantee a quality product, pharmacists' manufacturing processes should meet certain standards. Scales must be tested regularly and weights should meet required standards. Raw ingredients should be stored correctly and batch numbers need to be recorded. COSSH requirements need to be met when handling substances such as coal tar or dithranol. Preparing one's own specials has become "a minefield", says Mr Fawdry.

These requirements together with time constraints have led to the most significant change in the specials market over the past ten years. Today, pharmacists are more likely to order an item from a specials manufacturer than attempt to 'make it up' in the dispensary.

A 'clean room' at Eldon Laboratories

No limits

As well as manufacturing its own specials lines, Eldon can obtain products from other sources, for example, unlicensed or foreign preparations. There is virtually no limit to the medicines that the company can supply. "If we don't make it, we can obtain it," claims Mr Fawdry. But staff use their discretion when, for example, a very high strength preparation is ordered.

Eldon has Specials Manufacturing and Wholesale Dealing Licences granted by the Medicines Control Agency. It is also a registered pharmacy, with Mr Fawdry as its superintendent.

There are 15,000 different lines on Eldon's books with 30 new lines added daily. Many of these lines are pack size variants or different strengths of the same product, but about once a week, the staff are asked for a medicine which they have not previously supplied. If there is not a British Pharmacopoeia standard laid down, one is devised in-house.

There are "massive" quality assurance controls all the way through Eldon's production process. Every raw material is analysed, and regular checks are carried out by the MCA on all aspects of production.

Eldon's is a high cost business. It is similar to bespoke tailoring, according to Mr Fawdry, because of the individuality of its products. It is even possible for pharmacists to specify the brand of tobacco required in diamorphine reefers.

Because there is little difference in the quality of products supplied from different specials manufacturers, Eldon has to focus on "service, service, and service", says Mr Fawdry. Eldon has developed a reputation for customer service by providing more than just manufacturing facilities. To be successful, Mr Fawdry believes "you've got to do everything and you've got to do it all the time".

A large part of Eldon's service is the advice it offers. Pharmacists are always available to answer queries and to give advice on any of its products.

Staff go out of their way to ensure medicines are supplied quickly and efficiently. When a request was received for an unusual paediatric suspension, tablets had to be obtained direct from the manufacturer overnight. The suspension was manufactured next day and received at the pharmacy the following day.

Rapid growth has seen the company expand from a staff of three in 1995 to 33 today. The team includes 13 scientists, nine of whom are graduates, five pharmacists and even a podiatrist with pharmacy experience. The four customer services personnel deal with more than 200 orders daily.

About 90 per cent of orders are dispatched within 48 hours, usually by next day courier. Orders can take longer when products or ingredients have to be obtained from another source.

The competition

Eldon's main competitors are Boots Contract Manufacturing and Martindale. Both BCM and Martindale have a "large captive audience" in the Boots and Lloyds chains, and while demand within the specials market is consistent, it is limited. Although the lion's share of its business comes from independent pharmacies, a few branches of all the multiples use Eldon for some lines, and it is the first choice supplier for Moss Chemists.

Mr Fawdry's industrial pharmacy career began with his pre-registration year in industry at the Wellcome Foundation and the West Kent Hospital Service. Starting on bulk tablet manufacture, he later took charge of a clinical supplies unit.

Following a period when he "nearly bought a pharmacy", Mr Fawdry joined Penn, where he first became involved in specials. Penn sold its interest in specials and Mr Fawdry joined Eldon.

He believes the most important thing he has achieved during his three years at Eldon is bringing the right individuals together and forming an effective, customer focused team.

Appointed to the board in February, Mr Fawdry now plans to take a step back from the day to day activities and take a strategic overview. The company has opportunities for vertical integration, and expansion into other market areas, believes Mr Fawdry. But Eldon will still remain "firmly a specials company".

PHARMACYupdate

Gluten for punishment

Michelle Johnson, a community pharmacist with a special interest in coeliac disease, gives an overview of the disease and its management

Coeliac disease (CD) is a chronic disorder of the proximal small intestine, caused by sensitivity to gluten. It is characterised by loss of villous architecture, which leads to malabsorption and malnutrition.

Although coeliac disease was first recognised in 1888, it was not until 1950 that the relationship between CD and gluten was recognised by the Dutch paediatrician, W K Dicke. Since then, there has been considerable research into the pathophysiology of CD and isolation and identification of the coeliac toxic moiety of gluten.

Although our understanding of CD has advanced greatly since Dicke's observations, CD management remains unchanged: lifelong avoidance of gluten. However, accurate immunological screening tests can detect CD and identify patients for subsequent jejunal biopsy. Knowledge of the amino acid sequences of a coeliac toxic, gliadin, may facilitate the production of genetically engineered 'coeliac friendly' wheat.

But from the patient's perspective, perhaps the most significant advances in CD have been the enhancements in food technology that have led to the wide variety of gluten-free products currently available from pharmacies and health food stores.

The pharmacy potential for the supply of gluten-free products will be explored in detail in a follow up feature on the professional aspects of managing coeliac disease.

What is gluten?

Gluten is a protein found in wheat. Similar proteins are found in barley, rye and oats. The coeliac toxic moiety is contained in the alcohol soluble fraction of these proteins, called prolamins. Each cereal produces a different prolamin. These are:

- wheat – gliadin
- rye – secalin
- barley – hordein
- oats – avenin.

The role of oats in coeliac disease is controversial: many patients tolerate oats, but it is uncertain whether they should be advocated. The coeliac toxic amino acid sequence of a gliadin peptide is known to be present in secalin and hordein, but varies by a single amino acid in avenin. It is thought this difference may be sufficient to render avenin non-toxic.

Many experts, and also the Coeliac Society, still recommend the exclusion of oats. This takes account of the fact that commercial oat products are often contaminated with wheat starch during the milling process. If uncontaminated oats are proven safe, then they offer tremendous scope for enhancement of the coeliac diet.

The gluten content of cereals varies. Hard wheats grown in harsh climates have a high gluten content and are typically used for pasta (durum wheat) and strong bread flours. Soft wheats, grown in more temperate climates, have a lower gluten content and the flour produced from them is used for cakes, biscuits and pastries.

Many gluten-free flours are prepared from wheat starch that has been treated to remove gluten. Some traces remain and flours used in the preparation of foods labelled gluten-free must contain less than 0.3 per cent of wheat, barley, rye or oats protein. New European legislation will define gluten-free products in terms of their coeliac toxic protein (gliadin) content rather than total protein content. The level is expected to be 10mg gliadin per 100g of product.

Most coeliac patients can tolerate the trace amounts of gluten in gluten-free wheat-based products, but some super sensitive individuals require total gluten exclusion and must use flours derived from other sources like maize and rice.

Pathogenesis

Current knowledge supports the belief that coeliac disease is a unique inherited auto-immune disease that is absolutely dependent on continued exposure to the exogenous antigen gluten.

In affected patients, exposure to gluten initiates an immune response causing T lymphocyte infiltration of the small bowel mucosa. The subsequent release of cytokines and other inflammatory mediators causes inflammation of the villi and crypts of Lieberkuhn. Chronic exposure to gluten causes villous atrophy and the resulting flattened surface is much less able to absorb nutrients, leading to malabsorption (Figures 1 and 2).

The precise mechanism by which gluten causes damage to coeliac patients has yet to be

Continued on PII →

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1127), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JUNE 12, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To understand the role of gluten in coeliac disease
- To recognise the pathogenesis of coeliac disease
- To be aware of the role of inheritance and auto-immunity in the disease
- To recognise the symptoms of the disease
- To be aware of management

Continued from PI

elucidated, but many pieces of the jigsaw are known and are in keeping with the theory that CD is an inherited auto-immune disease manifest as a delayed hypersensitivity type reaction.

Evidence of inheritance

Coeliac disease is strongly associated with a particular human leucocyte antigen (HLA) genotype, HLA-DQ2, occurring in about 95 per cent of CD sufferers.

Familial tendency to CD is well documented and the likelihood of a first degree relative of a CD sufferer having the disease is 10-15 per cent. However, on close examination, risk is higher in siblings (40 per cent in on HLA matched sibling) than offspring (5-10 per cent). Concordance in identical twins is quoted as 70 per cent, but studies hove shown that apparently unaffected twins may have a tendency towards CD and go on to develop the disease later.

The HLA-DQ2 genotype is fairly common, occurring in obout 20 per cent of the population, and so some secondary genes or triggers, as yet unidentified, are likely to play a role in coeliac susceptibility.

Evidence of auto-immunity

Several antibodies are produced by coeliac patients exposed to gluten: anti-gliadin (AGA), anti-reticulin and endomysial (EMA) antibodies. AGA is not exclusive to coeliac disease and may be produced by healthy individuals. However, EMA, first reported in 1983, is known to be absolutely specific to coeliac disease and is specifically associated with continued exposure to gluten and only weakly associated with the inflammatory process.

In 1997, the auto-antigen for EMA was identified as the endogenous enzyme, tissue trans-glutominase (tTG). Gliadin hos a high substrate affinity for tTG and it is thought that gliadin is rendered coeliac toxic by tTG mediated deamidation of glutamin residues to glutamic acid and that the resulting enzyme substrate complex is the auto-antigen.

In typical auto-immune diseases, priming agents are responsible for initiating the immune response. Such agents mimic host molecules and, even after removal of the initiol foreign stimuli, the auto-immune loop is maintained by the host. Adenovirus infection has certainly been considered as a trigger for CD as it contains peptide sequences identical to a gliadin. However, the complete resolution of coeliac disease in the absence of gliadin is not consistent with conventional auto-immune hypothesis.

Associated conditions

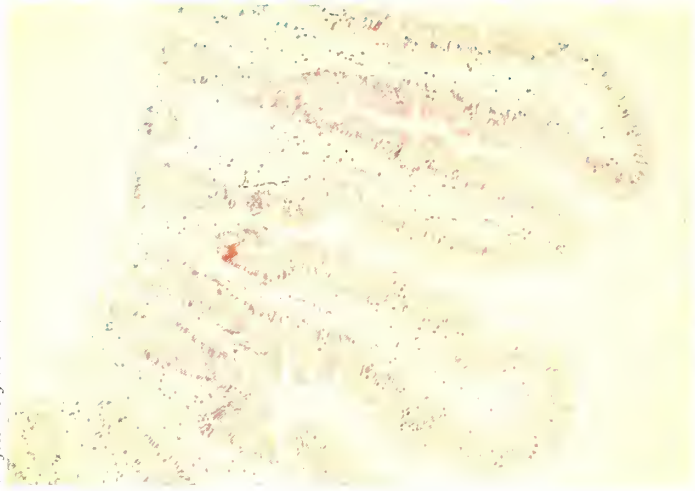
The HLA-DQ2 genotype is associated with o number of other auto-immune conditions and sufferers hove an increased tendency to coeliac disease.

The commonest related condition is insulin dependent diabetes mellitus (IDDM) and sufferers have a 1-7.8 per cent incidence of CD, which varies in line with the overoll prevolence of CD in the populations studied. UK estimotes ore usuolly quoted of 2-4 per cent. Other CD associated auto-immune diseases include Addison's disease, Sjogren's syndrome and auto-immune thyroidifis

Down's syndrome sufferers are at higher risk of CD, and a recent Australian study suggests up to a 100-fold increase in prevalence. A number of Italian studies have described a syndrome of coeliac disease and epilepsy with biloteral occipitol calcifications, while Irish reseorchers hove found o raised prevolence of coeliac disease in epileptics without cerebral calcification. The relationship between CD ond epilepsy is well documented buf ill defined. The prevalence of CD in patients with selective IgA deficiency is approximately 10 per cent, which has implications for screening.

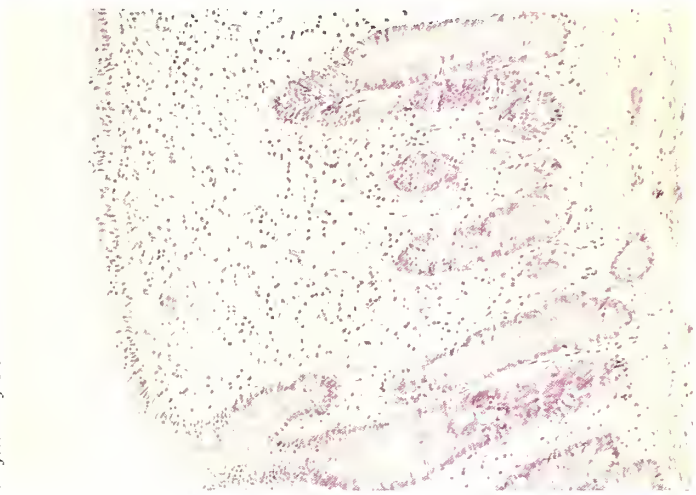
For many years the skin disease dermatifis herpetiformis (DH) was regarded as an associated condition, but is, in foct, an external manifestation of coeliac disease. Some 75 per cent of DH sufferers have some degree of villous atrophy ond on close examination the remainder can be found to have lymphocyte infiltration of the small bowel mucosa. IgA antibodies are found in the characteristic itchy blisters that oppeor on the elbows, knees and buttocks.

Dermatitis herpetiformis is far less common than CD with a quoted prevalence of one in 20,000, however, that figure too is under review. Onset is usually between the ages of 15 and 40 and it occurs more commonly in men than women (rotio 3:2).



Professor P J Ciclitira

Villi in a patient not suffering from coeliac disease



Professor P J Ciclitira

Villi in a patient with untreated coeliac disease

Prevalence

The prevolence of coeliac disease varies in occordance with the ethnicity and dietary habits of the study populations. It is most common in people of Celtic descent and in countries where wheat forms a staple part of the diet. Prevalence has also been shown to be higher in patients with certain associated conditions.

The incidence of CD reflects the number of diagnosed cases and is often confused with prevalence. Until recently, the incidence of CD in the UK was quoted as one in 2,500 and the prevalence estimated to be one in 1,000. However, several screening studies have shown the prevalence to be far higher and although these findings have had some impact on the rate of diagnosis, considerably more progress needs to be made.

Box 1
Signs and symptoms of adult coeliac disease:
- diarrhoea
- weight loss
- fatigue
- anaemia
- osteoporosis
- chronic mouth ulcers
- poor tooth enamel
- infertility
- recurrent miscarriage

In a *Lancet* paper in 1994, Catassi likened coeliac disease to an iceberg, with diagnosed clinically active disease representing only the tip. Below the surface lie many asymptomatic patients with histological evidence of CD (clinically silent) and even more patients with a predispositon to coeliac disease, but as yet no histological manifestations (latent disease). Latenf CD may become active after an illness or stress.

Prevalence is probably equally distributed between the sexes, but the incidence of CD is twice as high in women. Women may present during pregnancy or after childbirth and CD can delay the onset of periods, induce amenorrhoea and early menopause and also cause infertility and recurrent miscarriage. Women with untreated CD also tend towords low birthweight babies and an inability to sustain breast-feeding. Thus women have more triggers and greater opportunity for presentation and diagnosis.

A general practice cose study, reported in the *British Medical Journal* in January this year, described how a group of Oxfordshire GPs screened for coeliac disease. At the outset of the study, there were eight coeliac patients known to the participoting practices. After the first full year of screening, 30 new patients had been identified. These findings are in line with the widely held belief that for every coeliac diagnosed, there are four undiagnosed.

Coeliac disease was once regarded as a childhood condition, but the number of newly diognosed children is falling and the increased incidence is due to more frequent diagnosis in adults. The declining incidence of childhood CD may reflect better weoning practices and the fact that many commercially prepared foods for babies aged three to seven months are now gluten-free.

Adults are usually diagnosed between the ages of 30 and 40, but increasing numbers are being diagnosed aged 50 to 60. The average age of new adult members of the Coeliac Society is 50, which supports the widely held view that the increasing incidence

Continued on PIV →

Lodine* SR

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...replaces 200mg and 300mg strengths

IMPORTANT CHANGE TO PRODUCT RANGE

- The 200mg and 300mg immediate release forms of LODINE are being discontinued.
- **LODINE SR** is already much the most commonly prescribed form of etodolac.
- **LODINE SR** is the once daily 600mg sustained release formulation of the widely used[1] selective COX-2† inhibitor etodolac.[2,3,4,5]
- Convenient once daily dosing of **LODINE SR** can aid patient compliance.
- **LODINE SR** is better tolerated than immediate release etodolac.[6]
- Wholesalers have plenty of stocks of **LODINE SR**.

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ONCE DAILY

Lodine* SR

sustained release etodolac

COX-2 selective NSAID†

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Presentation: Lodine SR tablets contain etodolac 600mg in a sustained release formulation. **Uses:** Acute or long-term in rheumatoid arthritis and osteoarthritis. **Dosage and Administration:** Lodine SR tablets 600mg once daily. Safety of doses in excess of 600mg per day not established. Elderly - no change in initial dose generally required. Not recommended in children. **Contra-indications, Warnings etc:** Hypersensitivity, active peptic ulceration or a history of peptic ulcer disease (including gastrointestinal haemorrhage due to another non-steroidal anti-inflammatory drug), patients who experience asthma, rhinitis or urticaria during therapy with aspirin or other non-steroidal anti-inflammatory drugs. Pregnancy, during lactation. **Precautions:** Although non-steroidal anti-inflammatory drugs do not have the same direct effects on platelets as does aspirin, all drugs which inhibit the biosynthesis of prostaglandins may interfere, to some extent, with platelet function. Patients receiving etodolac who may be adversely affected by such actions should be carefully observed. In patients with renal, cardiac or hepatic impairment, especially those taking diuretics, caution is required since the use of NSAIDs may result in deterioration of renal function. The dose should be kept as low as possible and renal function should be monitored. However, impairment of renal or hepatic functions due to other causes may alter drug metabolism; patients receiving concomitant long-term therapy, especially the elderly, should be observed for potential side-effects and their drug doses adjusted as needed, or the drug discontinued. Serious gastrointestinal adverse effects such as bleeding, ulceration and perforation can occur at any time with or without warning symptoms in patients treated with NSAIDs. If any sign of gastrointestinal bleeding occurs, etodolac should be stopped immediately. Regularly review long-term patients e.g. for changes in, renal function, haematological parameters, or hepatic function. Use with caution in patients with fluid retention, hypertension or heart failure. **Drug Interactions:** Highly protein-bound drugs, e.g. anti-coagulants. Rarely prolonged prothrombin times with warfarin. Concomitant use of cyclosporin, digoxin or lithium with NSAIDs may cause an increase in serum levels of these compounds and associated toxicities. Bilirubin tests can give a false positive due to the presence of phenolic metabolites of etodolac in the urine. **Side Effects:** Reported side-effects include nausea, epigastric pain, diarrhoea, indigestion, heartburn, flatulence, abdominal pain, constipation, vomiting, ulcerative stomatitis, dyspepsia, gastritis, haematemesis, melaena, rectal bleeding, colitis, vasculitis, headaches, dizziness, abnormal vision, pyrexia, drowsiness, tinnitus, rash, pruritus, fatigue, depression, insomnia, confusion, paraesthesia, tremor, weakness/malaise, dyspnoea, oedema, palpitations, bilirubinuria, hepatic function abnormalities and jaundice, urinary frequency, dysuria, angioedema, anaphylactoid reaction, photosensitivity, urticaria and Stevens-Johnson syndrome. The more serious adverse reactions of gastrointestinal bleeding and peptic ulceration have been reported occasionally. NSAIDs have been reported to cause nephrotoxicity in various forms and their use can lead to interstitial nephritis, nephrotic syndrome and renal failure. Occasionally blood disorders have been reported.

Pharmacological Particulars: *Inhibition of Prostaglandin Synthesis and COX-2 Selectivity:* All non-steroidal anti-inflammatory drugs (NSAIDs) have been shown to inhibit the formation of prostaglandins. It is this action which is responsible both for their therapeutic effects and some of their side-effects. The inhibition of prostaglandin synthesis observed with etodolac differs from that of other NSAIDs. In an animal model at an established anti-inflammatory dose, cytoprotective PGE concentration in the gastric mucosa has been shown to be reduced to a lesser degree and for a shorter period than other NSAIDs. This finding is consistent with subsequent in-vitro studies which have found etodolac to be selective for induced cyclo-oxygenase 2 (COX-2, associated with inflammation) over COX-1 (cytoprotective). Furthermore, studies in human cell models have confirmed that etodolac is selective for the inhibition of COX-2. The clinical benefit of preferential COX-2 inhibition over COX-1 has yet to be proven. *Anti-inflammatory Effects:* Experiments have shown etodolac to have marked anti-inflammatory activity, being more potent than several clinically established NSAIDs. **Product Licence Number:** Lodine SR tablets: 0011/0197 (600mg). **Basic NHS Cost:** £15.50 for 30 x 600mg SR tablets. **Date of Preparation:** March 1999. **Legal Category:** POM. For full prescribing information please refer to data sheet. **Product Licence Holder:** Wyeth Laboratories, Huntercombe Lane South, Taplow, Maidenhead, Berks SL6 0PH. **Supplied by:** Monmouth Pharmaceuticals Ltd., 3 & 4 Huxley Road, The Surrey Research Park, Guildford, Surrey, GU2 5RE.

References 1. 82 million prescriptions world-wide in the last 6 years (IMS health data) 2. Simon L., J.Clin.Rheumatol., 1996; 135-140 3. Riendeau D., et al., British Journal of Pharmacology, 1997; 121: 105-117 4. Kawai S., European Journal of Pharmacology, 1998; 347: 87-94 5. Glaser K., Inflammopharmacol., 1995; 3: 335-345 6. Dreiser R.,Rhematol.Int., 1993, 13, 2: S13-S18

†Demonstrated in-vitro and in human whole blood assays. The clinical benefit of preferential COX-2 inhibition over COX-1 has yet to be proven.

MONMOUTH PHARMACEUTICALS

Further information available on request from:
Monmouth Pharmaceuticals Ltd., 3 & 4 Huxley Road, Surrey Research Park, Guildford, Surrey GU2 5RE

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April 1999

LOD 142

Box 2
Patients are at higher risk of coeliac disease if they have:

- a first degree relative with CD
- IDDM (2-4 per cent)
- auto-immune thyroiditis (2-4 per cent)
- Down's syndrome
- selective IgA deficiency
- idiopathic epilepsy

Continued from PII

of CD is a diagnostic phenomenon. More than twice as many patients over 60 joined than patients under 16.

In 1997, The Coeliac Society reported a record increase in new members for the second year running. Membership at the end of 1997 totalled 32,334. Estimates suggest that only half of all diagnosed coeliacs register.

Presentation

The presentation of coeliac disease in childhood and adulthood differs. Child health surveillance often detects CD before children become severely malnourished, although most are below the 50th centile for weight at diagnosis. Florid symptoms are unusual and CD is usually detected during the child's first year, after introducing cereals at weaning.

Although diarrhoea is the most frequent complaint, constipation may also be a presenting symptom. The diarrhoea may contain large amounts of undigested fats and the resulting stool is characteristically pale, bulky, offensive and difficult to flush away (steatorrhoea).

Vomiting is a common feature in childhood CD, occurring in about 50 per cent of children. Abdominal pain is the third most frequent complaint and coeliac children often have abdominal distension.

Clinical presentation in adulthood is enormously variable (Box 1). Classical symptoms associated with malabsorption are diarrhoea (steatorrhoea), weight loss and weakness. However, a recent prospective study published in the *British Medical Journal* found many patients to have a body mass index in the normal range or even to be overweight at presentation. Both iron deficiency (microcytic) and folate deficiency (macrocytic) anaemias occur quite frequently. Anaemia and fatigue (tired all the time – TATT in GP speak!) were the commonest presenting symptoms in the Oxfordshire study.

However, many patients present with vague, ill-defined symptoms and are frequently misdiagnosed, most commonly with irritable bowel syndrome (IBS). Ironically, no IBS patients screened in the Oxfordshire study were found to be undiagnosed coeliacs. Of course IBS and coeliac disease can co-exist.

More unusual presentations in patients with clinically silent disease include recurrent mouth ulcers, defects in tooth enamel and male or female infertility.

Presentation in the elderly may be due to the development of long-term complications of coeliac disease. In 1995 a study of newly diagnosed elderly patients found 15 of the 35 patients aged over 60 years had consulted their GP for on average of 28 years with various symptoms before diagnosis was made.

Early detection

Early diagnosis of coeliac disease is important to ensure the long-term health of the patient. In patients with significantly active disease, the immediate risks associated with malabsorption and malnutrition are obvious. However, it is important to identify patients with milder disease as they too are also at risk of compromising their health.

Patients will exhibit the effects of nutritional deficiencies which in turn may lead to metabolic disturbance. In particular, villous atrophy leads to reduced calcium absorption and coeliac patients have low bone mineral density. In females this may be compounded by the effects of early menopause.

Osteoporosis and osteopenia are common features of untreated coeliac disease. Early diagnosis is essential as peak bone mineral density is reached in early adulthood. Bone mineralisation improves on a gluten-free diet.

As noted earlier, exposure to gluten stimulates lymphocyte infiltration of the small bowel mucosa. Chronic infiltration leads to the development of a high grade T cell lymphoma of the small bowel, a type of cancer that has a very poor prognosis (five year survival rate is 5 per cent). CD sufferers have a 100-fold increase in risk of developing lymphoma, however risk returns to that of the general population in patients observing a strict gluten-free diet. Other malignancies that occur more frequently in untreated coeliacs include oesophageal and pharyngeal lymphomas and small bowel adenocarcinomas.

Diagnosis

Adult presentation of coeliac disease in particular can be very vague. Blood tests may reveal anaemia and a raised erythrocyte sedimentation rate (ESR is indicative of inflammatory disease) and together with other symptoms, they may suggest a possible diagnosis of CD. Fortunately, antibody screening is now available to screen patients prior to performing a small bowel biopsy.

Antibody screening is the most sensitive method for detecting CD and allows high risk patients to be screened (Box 2). Although IgA anti-endomysial antibody is specific for CD, tests are not sufficiently sensitive for use alone. However the positive predictive value of combined IgG and IgA anti-gliadin and IgA anti-endomysial antibody levels is 98-99 per cent in the best centres. Results are less reliable in laboratories that perform only a few tests. It is important to include an IgG anti-gliadin antibody screen to detect those coeliacs with selective IgA deficiency.

Despite the sensitivity and specificity of screening, an endoscopic jejunal biopsy is required to confirm the diagnosis. It is essential that the biopsy is performed while the patient is on a gluten containing diet. Withdrawal of gluten from the diet allows the villi to recover and may delay diagnosis as the patient will have to undergo a gluten challenge and repeat biopsy.

Management

Once coeliac disease is confirmed, the patient is referred to a state registered dietitian who will advise on diet management. Unfortunately, some patients have to wait several weeks for an appointment at a time when they are desperate for information, advice and something safe to eat!

It is not uncommon for newly diagnosed patients to experience a wide range of emotions. They may be relieved to have a diagnosis, particularly if they were worried about malignancy, and that all it takes to be well again is a few changes to their diet. Sometimes they are shocked by the dietary restrictions and angry that this has happened to them. They may deny the existence of the condition. They may grieve for the things they can no longer eat and worry about how they will cope. Their social life may change dramatically: eating out, going on holiday can all suddenly seem intimidating.

Management is quite simply a strict gluten-free diet for life. It may be necessary to correct nutritional deficiencies present at diagnosis, but long-term supplementation is rarely required if the patient follows a balanced diet. Once on the diet, symptoms resolve rapidly (within a few days/weeks) for one third of patients, another third improve within a few weeks/months and the remainder within a year. Persistent symptoms are rare in fully compliant patients.

Although the mainstays of a gluten-free diet are natural gluten-free foods such as meat, fruit, vegetables and dairy produce, gluten-free substitutes add variety and are a source of carbohydrates.

The Coeliac Society encourages sufferers to foster a relationship with a single pharmacy. Dietitians welcome pharmacists able and willing to support patients in primary care. A good pharmacist is often the most important healthcare professional in a coeliac sufferer's daily life. Sadly, research shows that many of us are not getting it right. A follow-on feature will discuss how we can best build and serve our coeliac clientele for mutual benefit.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2000.*

KEY POINTS

- coeliac disease is an inherited auto-immune disease
- symptoms are precipitated by exposure to gluten
- currently only one in five patients is correctly diagnosed
- incidence is declining in children and rising in adults
- screening is available for high risk patients
- management is by strict gluten-free diet for life
- poor compliance greatly increases the risk of serious complications

RESOURCES

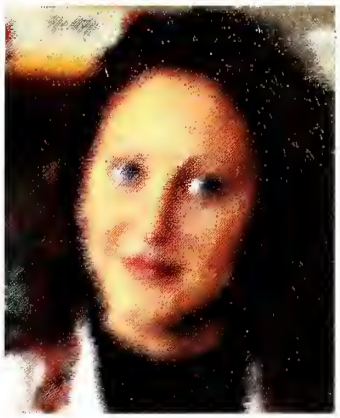
The Coeliac Society, PO Box 220, High Wycombe, Bucks HP11 2HY. Tel: 01494 437278. The Coeliac Society is a registered charity which provides help and information to sufferers and healthcare professionals.

ACTION PLAN

1. In your practice workbook note the symptoms of coeliac disease in an adult.
2. Do you have any patients who have presented with these vague symptoms at the pharmacy? How can you distinguish between patients who say they have IBS and those with coeliac disease?
3. Look through the Drug Tariff section for foods permitted for gluten sensitive patients. Use this information to help known coeliacs enlarge their diet.
4. Distinguish between gluten-free And wheat-free products.
5. Encourage diagnosed coeliacs to contact and join the Coeliac Society.
6. Contact the Coeliac Society for resources and useful contacts. Make contact with the state registered dietician in your area and see if you can help local coeliac patients.

Denying a drink problem

A man in his 30s is in denial about his drink problem and the extent of his cirrhosis. Three months later he dies in hospital. Primary care pharmacist Mary Allen looks back at what went wrong



Jack Doniels wos o mon in his lote 30s. Pharmocist Janet first dispensed his medicines on a June morning ond wos immediately struck by his yellaw skin, yellow eyes ond the smell of alcahal at 10.30am! The following week, she found herself dispensing onather prescription for him, this time braught in by a specialist polliotive core nurse. His prescriptian medicotion records (PMR) indicoted thot he hod o variety of medicines dispensed at irregulor intervols over the previous few months.

Janet subsequently learned that Jock hod o history of heovy drinking, which had coused the breokdawn of his morrioge. He wos in deniol obout the extent af his cirrhasis ond continued to drink. He wos referred by his GP to the locol palliotive core team, ta provide respite far his mather os well. He wos known to be non-camplionl with his medicines. He died peocefully in hospitol three manths loter, odmitted following o fall which left him bruised, in greot poin ond suffering from breathlessness.

The prescription

Chlorpheniramine syrup	2mg *nocte* only
Temazepam elixir	10mg *nocte*
Sudocrem	*mdu* 100g

From phormocy PMR, Jonet nated thot the following drugs hod been dispensed intermittently over the previous few manths:

Multivitamins	1 doily
Thiamine	100mg doily
Vitamin B Co Forte	twa doily
Frusemide	40mg *mane*
Spironolactone	100mg doily increosing ta 200mg doily
Codeine phosphate	15mg i-ii *tds prn* for poin
Propranolol	40mg *bd* prescribed by hospitol doctar
Codeine phosphate	30mg *nocte* for diorrhoeo and pain
Frusemide	40mg *mane*

What complications are associated with cirrhosis and how are they treated?

Cirrhasis is o chronic liver condition chorocterised by widespreod hepatacellular domage and intrahepotocellulor nodulor scorring. The nodules obstruct blaad and biliory flow within the liver. Treotment is obstinence from olcohol, nutritional suppart and the treatment af mojor complicotions of cirrhosis which ore:

- portol hypertension
- ascites
- encepholopothy
- bleeding disorders
- oesophogeal vorices (ond/or gastric bleeding ond/or hoemarrhoids)
- hepotorenol syndrome.

Other symptams include weight loss, onorexia, diorrhoeo, vomiting, weokness, fotigue, obdominol discomfort, pruritus ond polyneuropothy.

1 Portal hypertension

The partal venous system tronsports blood from the digestive troct, poncreas and spleen ta the liver. Portol hypertension is on increosed pressure in the partal vein due to obstruction of introhepotic blaad and biliary flaw coused by liver nadule formotion in cirrhosis. Bock pressure in the vein leods to development of colloterols in the systemic venaus system. This moy couse vorices in the oesophogus, which con produce profuse bleeding (hoematemesis – requires emergency treotment ond could be fotol), ond ot other oreos of the GI troct resulting in gostric bleeds ond/or hoemorrhaids.

Treatment af portol hypertension is with propronolol, which decreoses portal pressure ond hepotic blood flow through beto-odrenergic blockade. Liver functian deteriarates in portol hypertension, so o low dose, typicolly 40mg twice doily, is used.

2 Ascites

Ascites is on accumulotion of fluid in the peritoneol cavity. Contributing foctars include:

- increased pressure in the partol vein cousing fluid to leok into surrounding tissue
- decreased olbumin productian in the cirrhosed liver, resulting in lowered venous pressure, olso cousing leokoge
- fluid exuding directly from the liver surfoce into the obdominol covity.

Treatment is with spironoloctone 50mg doily increosing slowly ta 400mg doily if required. Frusemide 20-40mg may be given if spiranaloctone foils (or while woiting for spironoloctone ta take effect). Refroctary cases moy require lorge doses of frusemide and spironalactone together. If possible, sodium intoke shauld be restricted ta 10-20 milli-equivolent No+ ond bed rest helps. Some patients underga porocentesis (droinoge of abdominal covity vio insertion af fine cotheter): removol of 1-2 litres provides relief of obdominol poin ar respiratory distress.

3 Blood disorders

Chranic olcaholism con couse thrombacytopenio, coogulotion prablems ond mocrocytic onoemio. Thrombacytopenio results from interference with plotelet farmotion. Prothrombin time increoses in hepotic cirrhosis due to reduced synthesis of clotting factors. This moy be due to reduced absorptian af Vitomin K from the gut, to poor nutrition ar to reduced liver copocity for synthesis. Thrombocytopenio ond/or increosed clotting time produces bleeding or bruising.

Some potients receive blood or plotelet tronsfusians. Some benefit fram slawly injected i/v Vitamin K (i/m injections ore contro-indicoted os they couse poinful locol bleeding).

Continued on PVI →

Continued from PV

Jack's platelet caunt was very law and he had several blaad transfusians in haspital ta treat this. His skin needed a great deal af nursing care as his cantinuol scratching (due ta his pruritus) caused him ta bleed.

Macracytic anaemia accurs in oround 30 per cent af patients with chranic alcahalism.

Falate deficiency is the most frequent cause, usually thraugh dietary deficiency (lack af green leafy vegetables, liver) but impaired absorption, retentian ar starage may accur. Falic acid supplements help.

Other symptoms af chranic alcaholism include weight lass, anarexia, diarrhaea, vamiting, weakness, fatigue, abdaminal discamfart, pruritus and palyneuropathy.

- Thiamine is frequently prescribed ta prevent ar treat polyneurapathy which may accur with cirrhasis. Other vitamin B graup supplements may be given where diet is knawn ta be paar.
- Diorrhaea, vamiting and weight lass were all seen in Jack's case. He was prescribed cadeine phasphate far pain and diarrhaea.
- Jaundice and pruritus were evident in Jack's case. Chlarpheniramine was prescribed ta ease the intense itching caused by deposits af bile products under the skin.

What lab tests would provide further confirmation about Jack's hepatic function?

Blaad tests would provide useful infarmation. Knawn as Liver Functian Tests, they da nat directly measure hepatic functian but instead measure levels of certain enzymes which are cammanly raised in hepatic impairment.

In particular, raised levels af gamma-glutamyl transpeptidase (GGT) are suggestive af high alcahal intake, increased alkaline phasphatase (AP) levels can indicate chalestatic jaundice and/ar cirrhasis. Aspartate aminatransferase (AST) levels tend ta be increased in hepatic necrasis. Plasma albumin levels are reduced in cirrhasis due ta the reduced manufacturing capacity af the liver.

Jack's liver functian tests did indicate hepatic damage cansistent with chranic alcahalism. His AST levels were 125iu/l (narmal range 10-40iu/l); GGT levels were 350iu/l (11-50 far males) and AP 189iu/l (30-90iu/l). His plasma albumin levels were 25gm/l (35-50gm/l).

Should Jack's prescription be dispensed as it stands?

Jock has been prescribed a very small dose of chlorpheniramine, probably ta treat the prafaund itching that can accampany jaundice. He has also been prescribed temazepam in a narmal adult dase and Sudacrem, possibly ta saathe his itching.

In severe liver disease many drugs can further impair cerebral functian and may precipitate hepatic encephalapathy. These include all sedative drugs, opioid analgesics, those diuretics which cause reduced plasma patassium levels, and drugs that cause canstipatian (*BNF* Appendix 2). The *BNF* appendix recammends avaiding chlarpheniramine and using only small doses af temazepam.

Hepatic encepholopathy is a metabalic disorder af the CNS causing altered mental status ranging fram mild canfusian ta cama, tagether with asterixis (a flapping tremar af the hyperextended wrists) and fetar hepaticus (a peculiar, musty smell af the breath). It is exacerbated by GI bleeding, metabalic and electralyte abnarmalities, and volume depletian (caused, far example, by diuretic therapy ar paracentesis), and by CNS depressant drugs. Canstipatian and infectian may alsa act as triggers. Biachemical changes include abnarmal ammania metabalism, and altered amina acid ratias.

Subsequently, it was seen that Jack had been receiving bath chlarpheniramine and temazepam fram a variety of prescribers (GPs and hospital doctars) and fram a variety of pharmacies aver a periad af several manths. He was faund ta be non-compliant with his chlorpheniramine – he didn't take it as it 'made him taa drawsy'. He had, hawever, been taking temazepam an and off for some manths.

Jack's PMR shaws that he had alsa previausly been prescribed cadeine phasphate ta treat pain and diarrhaea. The nurse's nates shawed that he refused paracetamal, cancerned that this could affect his liver! Judging by the battles in his flat, he taak very little codeine.

Jock's temazepam dase was reduced ta 5mg at night. Fallawing the second prescriptian that Janet dispensed for him (temazepam elixir 5mg at night if required) na mare prescriptions were dispensed far Jack at the pharmacy.

When Janet saw the palliative care nurse same weeks later she asked what had happened to Jack and learned that he had recently died in haspital. He had been admitted after a fall fallawing a drinking baut. At the time, he had been very canfused, short af breath and in a great deal of pain with generalised bruising.

Fallawing Jack's fall he was prescribed Oramarph (marphine sulphate salutian 10mg/5ml) far dyspnaea (shartness af breath) and pain (his impaired blaad-clatting mechanisms probably warsened his bruising and pain). Although he gained some relief fram the marphine, it could trigger encephalapathy. His dyspnaea may have been a result af his prafaund ascites causing pressure on his diaphragm. It may alsa have been associated with renal failure.

Could anything have been done to save Jack?

Jack's prognosis was doomed as he was in denial about his canditian and refused ta stap drinking alcahal. He was nan-compliant with his medicatian ather than temazepam, which probably caused ar exacerbated his confusion and may have cantributed to his fall. He was fartunate in having home care fram a palliative care nurse as his illness pragressed ta a terminal stage, and he died a peaceful death in haspital.

Hawever, claser collabarative care between health professionals may praduce mare focused care far patients like Jack. His pharmaceutical care was pravided by variaus dactars and thraugh several pharmacies, with na ane aware af the complete picture. Janet's invalvement had been minimal – much af the infarmation was learned anecdatally fallawing Jack's death. A pharmaceutical care plan, thraugh ane pharmacy/pharmacist, could have helped identify nan-campliance and inapprapriate dases.

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Migraine is not life threatening but it can have a huge impact on the quality of life. One woman outlines her particular experience and symptoms of the condition

Migraine

Although the debilitating effects of migraine attack are well documented, it is still widely regarded as just a headache: we should take a couple of aspirin and stop making a fuss.

During a severe attack, I suffer from the whole spectrum of symptoms. The first indications are a slight stiffness in my neck, an inability to articulate clearly and almost complete gobbledygook on my word processor screen.

Visual disturbances follow, such as blind spots in the vision surrounded by multi-coloured zig zag patterns; pulsating pain on the left side of my head which progresses until every fibre of my head and face is throbbing; stiffness of the neck with stabbing pains shooting from the back of my neck through to my left eye; nausea and vomiting; pins and needles and numbness down the left side of my body; intolerance of light, sound and smell.

Although all I want to do is rest in a quiet, darkened room, sleep is impossible as there is no position which can provide any relief from the pain. Closing my eyes causes the lights to flash still brighter and more alarmingly, and disturbs my balance – even when I'm lying down, the room begins to spin. If I do manage to nod off for a short time, frightening nightmares soon wake me.

It is a common fallacy that all migraines can be cured by the avoidance of cheese, red wine and chocolate. If only it were that simple.

Factors that can trigger a migraine attack are numerous and varied including bright lights, flickering lights or shadows, strong sunshine, loud noise, vibrant patterns and colours, smoking, an enormous variety of foods, fasting or long periods between meals, stress, tiredness, a variation in sleep pattern, stuffy rooms and strong smells.

I know that I must keep my blood sugar constant and never allow myself to go for more than three hours without food during the day or ten hours overnight as this would almost certainly trigger an attack.

However, an attack may also occur when several other factors which usually leave me unaffected come together at the same time. For example, if I have had a long and stressful day in a stuffy room with people smoking and then someone sits next to me on the train wearing a strong perfume I would immediately reach for my medication.

Finding the successful treatment is very much a matter of trial and error. In retrospect, I now realise I'd had migraine even as a child, but I just had not recognised it at the time.

Because the attacks were reasonably infrequent, my parents didn't even think to take me to the doctor. When I was in my 20s, the migraine attacks got worse and in my 30s they got so bad that I had to seek treatment. There weren't many treatment options at that time, 5-HT agonists didn't arrive until 1990. This class of drug changed the lives of many migraine sufferers.

I make sure I eat regularly – that aspect of migraine has made a difference for me. A weekend lie-in would sometimes trigger migraine so I try to make my sleeping pattern as regular as possible.

I also took up yoga because relaxation helped me. Stress was a particular problem for me.

In addition to pain, migraine patients experience frustration that the attacks won't let them get on with their lives, annoyance that their bodies are letting them down in this way, guilt when they have to let down family, friends or employers and work colleagues and a lack of confidence which makes them reluctant to make plans or take on new responsibilities. Migraine is not life threatening but it can have a huge impact on your quality of life. Any suggestions that we are malingerers or that 'we bring it all on ourselves' are both unfrue and cruel.

RESOURCES

The Migraine Trust. 45 Great Ormond Street, London WC1N 3HZ. Tel: 0171 278 2676. Funds research into migraine to improve diagnosis and treatment. Also holds international symposia and offers help and information to sufferers.

The Migraine Action Association. 178A High Road, Byfleet, Surrey KT14 7ED. Tel: 01932 352468. Provides support to members plus information on all aspects of migraine.

Marbella was the venue for last week's AAH Vantage Convention, and the new management team was out to make an impression

Vantage aims for the virtual chain

Steve Dunn: 'Pharmacy is not integrated into the healthcare system'

If independent pharmacy is to defend its market viability, a "key strategic imperative" is to achieve the scale and discipline of a chain, AAH Pharmaceuticals' new md, Steve Dunn, told the Convention.

Vantage remains the UK's largest symbol group with 2,200 members, but "the critical dynamic in the market is concentration". Today, seven groups own 3,882 pharmacies, or 31 per cent of the UK total. Independent pharmacists have to deal with this issue.

The Government perceives pharmacy more as a delivery system rather than a healthcare mechanism, said Mr Dunn. "To some extent, this is our fault. Pharmacy lacks a single voice and message, and is not integrated into the healthcare system."

To overcome the various threats it faces, community pharmacy needs to develop new sources of healthcare based income and become better at retailing, he said.

"It needs to become relevant to the NHS and the Government, to add value and not be seen just as a distribution mechanism. It needs to survive a discount enquiry which could take as much as £20,000 off the bottom line of the average pharmacy in the next two years. And it needs to survive PCGs, or trusts as they will be in five years' time, which may have such rights as buying direct from manufacturers and using contracts themselves."

CHS – the way ahead?

The introduction of Community Health Services has gone "extremely well", said Mr Dunn. In a 33-pharmacy pilot over a 20-week period there has been an average of two tests per week per pharmacy.

The average price paid has been £20 per test (the highest was £50), and the average margin has been £8. There has been a related sale opportunity, and the customer has been an older, upmarket and female customer – "just the sort of consumer we need in pharmacy".

Refreshing results

The Vantage Refresh programme is producing results, said Mr Dunn. Introducing category management and monthly product sector merchandising produced significant volume uplifts in pilots – an 18 per cent uplift in VMS tests and 9 per cent in haircare.

'Refreshed' stores have shown an increasing rise in footfall compared to a Super Vantage control group, rising from 21 per cent higher in September 1998 to 68 per cent by November. Counter medicine sales grew faster than in the control group and monthly promoted lines "really took off", he claimed.

There are 388 active Refresh members: 178 have requested new fascias, and 61 have requested full Vantage refits. Another 100 are "coming on-stream right now and we are on target for 700 by the end of the year".

A radio and press advertising campaign is being tested in Northern Ireland this month. The programme is also being rolled out this month to stores supplied by the Bristol, Swansea, Weedon and Paignton depots. Ruislip and Bexhill will follow in June and Southampton, and Aberdeen in September.

At the end of May, full category management will be introduced, with a merchandising implementation team and category management packs for each product sector. VMS will be followed baby, cough/cold, dietetics, GI, oralcare, family planning, first aid and footcare by the end of the year.

Information technology will also be introduced into the demand chain through initiatives such as FSM and Point (see p22).

"Vantage Refresh is about stabilising the front shop business, about managing the supply chain, about stopping the rot, but we must move on to the integrated delivery of professional services, representing a new source of income from consumers, replacing the loss of OTC income within the mix and eventually allowing Vantage Pharmacy to integrate with PCGs and become true health centres," he said.

Number of stores in 1998

Lloyds	1275
Boots	1287
Moss	571
NCC	266
Tesco	201
Superdrug	175
Safeway	99

Seven groups, 3,874 pharmacies, 31 per cent of the total

The writing on the wall

'Medicine has lost its way'... 'We are lumbered with a style of medicine which is misfitted to the illnesses of the 20th century'... 'Medical care as provided by physicians is having less and less impact on the health of people in industrialised nations'.

Many doctors and lay people believe that in modern industrial societies the main causes of death are cancer and heart disease. The counterview is that the main killers are the lack of social support, poor education and stagnant economies.

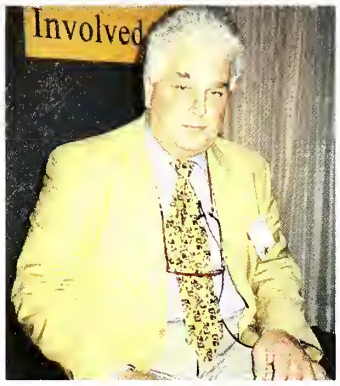
These views were put forward by GP Dr Malcolm Rigler to explain why the Government is seeking to change the way healthcare is delivered.

Dr Rigler practises above a pharmacy in Brierley Hill, Dudley, and is working with the Faculty of Health and Community Care at the University of Central England on the role and functions of healthy living centres in community practice.

He is also involved in putting together a £1 million bid for HLC funding, involving Lloyds Pharmacy.

"Position yourselves carefully," he advised. "Everything I have heard leads me to believe that GP and pharmacy practices will be changed beyond recognition."

He asked people to consider why the Government was ploughing £300 million into HLCs and £200m into



Dr Malcolm Rigler, a GP involved in healthy living centres in the community

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→Continued from P19

initiatives like the Kids' Club network.

He admitted to being strongly influenced by Dr Michael Wilson, a lecturer in health at Birmingham University, who wrote: "Our era is one of enormous pools of loneliness in densely populated cities, and alienation between races; our diseases are psycho-social, such as stress, heart attack, blood pressure, anxiety, violence, divorce [*sic*], abortion, ulcers and the effects of substance abuse such as alcohol and tobacco, plus the consequences of our lifestyle – obesity, car accidents, delinquency, pollution and unemployment."

It is time to rethink the whole philosophy on which healthcare is founded, said Dr Rigler. The original NHS view, that there is a limited pool of illness and disease, and that the provision of free medical care will lead to health has proved "just plain wrong".

The idea that mental and physical health might need support, and the notion that ill health results when a community is not functioning well, was never even considered.

Sustaining community health provision requires a great deal of vision, warned Dr Rigler. His prescription for working towards health improvements lies in education and especially in arts education and community arts.

His surgery is a focus for art, music and other projects that promote health in a primary care setting.

"If anything has to be done in the next year, it is to get health promotion on the PCG agenda," he said.

Jeff Poole will be remembered from Marbella as 'the man with the mike'. He was keen to rectify misconceptions (which, regretfully, *C&D* contributed to) that he is relinquishing his job at Enterprise and Trident. For the record, he is taking on the role of group sales director at AAH Pharmaceuticals in addition to his current responsibilities as md of AAH's Enterprise division

MARBELLA

Dependent prescribing offers a bigger role

Prof Claire Mackie: pharmacists must be given the keys to the NHS

Fundholding acted as a catalyst for the development of pharmacy in primary care. The switch to primary care groups means pharmacists will not have to throw away the experience they have gained.

Pharmacists have a bright future and are well placed to develop their role in medicines management, said Professor Claire Mackie, head of the School of Pharmacy at Robert Gordon University, Aberdeen. This will be helped by recommendations in the Crown Review (she was a member).

The final part of the Review is a consultation document. The deadline for comments is June 7.

It looked at two types of prescriber. **Independent prescribing** is something pharmacists have been doing for years when responding to symptoms of minor illness with P and GSL medicines.

Around 33 per cent of the population are self-medicating at any one time, and OTC medicines account for around a quarter of total medicine sales. This makes self-medication a cost-effective component of all healthcare systems.

The case mix seen by pharmacists and GPs who are consulted over minor ailments is very similar, which suggests that if pharmacists were given an independent prescribing role they would be able to take on a lot of complaints being presented to GPs.

There has also been a subtle shift in the licensing system which has empowered patients to manage chronic diseases, rather than self-limiting illness, with OTC products.

This shift means pharmacists need access to a single, integrated patient record, and evidence of clinical effectiveness. It also raises the question of patient registration. "Pharmacists cannot be gatekeepers to the NHS unless they are given the keys," said Prof Mackie.

Dependent prescribing offers a bigger role for pharmacists. There are two possibilities:

- initiation of therapy following medical diagnosis
- continuation or modification of the original prescription in response to monitoring the patient.

Initiation of therapy following medical diagnosis is not new. It was proposed in a joint DoH RPSGB report 'Pharmaceutical care – the future for community pharmacy' in 1992.

Continuation prescribing is "the big one". Repeats make up 60 per cent of prescription volume and account for 80 per cent of prescribing costs.

The risks of repeat prescribing are evident. There may be poor disease control, treatment may continue beyond its therapeutic benefit, there may be poorly recognised adverse reaction and drug wastage.

A medication review project carried out in Glasgow in 1995 monitored 3,296 patients from six medical practices on four or more drugs. Patient participation was high, at 59 per cent. Of these, 84 per cent were referred, and in only 3 per cent of cases the issues raised by pharmacists were rejected.

The top five clinical issues identified were:

- unnecessary therapy (24 per cent)
- ineffective therapy (12 per cent)
- no routine monitoring (11 per cent)
- inappropriate therapy (11 per cent)
- admitted non-compliance (11 per cent).

An analysis showed a saving of £26 per patient. But the health gain was the biggest benefit – health budgets are there to be spent, said Prof Mackie. "The aim should not be to save money but to spend it properly."

If pharmacists are to move in this direction, they need to create a more professional environment in-store. More space should be devoted to counselling and advice areas.

Time and resource is the biggest challenge, and new remuneration models need to be explored. Training will be needed, and clinical skills developed, and more use will need to be made of trained staff.

SB

LOYALTY PAYS.

Paracetamol, Codeine and Caffeine

Paracetamol and Codeine

Satisfied customers are the foundations of a growing business

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Loyalty that can work for you

Brand loyalty as good as this can only work to your benefit. Which means that a simple recommendation for Solpadeine, and Solpadeine MAX for Maximum Strength Pain Relief - is not only giving the customers fast and powerful relief from pain, it pays by helping to keep the tills ringing as you grow your business. Remember – Solpadeine is the leading pharmacy analgesic with a cash market share of 16.1% - **significantly higher than any other brand!**[3]

THE **No.1** PHARMACY ANALGESIC

References 1. Taylor Nelson AGB Superpanel 1997. 2. Taylor Nelson Sofres Healthcare 1998. 3. IRI Infoscan, November 1998.
SmithKline Beecham Consumer Healthcare, SB House, Brentford, Middlesex, TW8 9BD Solpadeine and Solpadeine MAX are trade marks

SB SmithKline Beecham Consumer Healthcare

The future belongs to those ready for IT

Pharmacists who use their computer only as a labelling machine that is capable of sending orders to their wholesaler are going to have to 'wise up' quickly. In retailing generally IT is used to run the entire business.

"You use it within your professional role – your comfort zone ... but beware. You will not be able to ignore the rapidly developing impact that IT will have on all businesses," warned AAH's marketing manager – customer technology, David Watkinson.

To maintain growth, pharmacists will have to integrate the front shop with the dispensary. For many pharmacies, traditional front shop sales will continue to decline, to be replaced by other income streams. Increasingly these new services will lead to more integral involvement with the healthcare team.

Individual pharmacies will be less independent, and more dependent on other pharmacies and management structures.

"This doesn't mean independent pharmacy will disappear – just that it will have to co-operate with others to a far greater extent, and that will require someone somewhere to fulfil a centralised management function," said Mr Watkinson.

Determining who will provide services in the future will not be about convenience or history: increasingly decisions will be financially driven, he predicted. Those who benefit from the economies of scale and management skills of larger organisations will be the winners.

There is no doubt that in the future prescriptions will be moved around electronically. "There will be no need for the pricing authorities to have to ask about the cost of goods. Payment will not be based on the artificiality of trying to disguise the cost of goods so that margin can be enhanced. Payment will be for services provided, not for goods supplied," said Mr Watkinson.

David Watkinson, AAH's marketing manager

Suppliers will have to provide systems to enable individual pharmacies to operate in a more integrated environment. 'Head office' systems will have to be developed to enable consolidation of data from within single businesses.

The infrastructure to collect such large volumes of data will lead to new partnerships, both commercial and professional, which will enable pharmacies to develop new services.

AAH is well positioned to help its customers when the investments in new technology start to bear fruit. "Someone somewhere will have to negotiate with suppliers and PCGs to ensure that new monies become available to pharmacies," said Mr Watkinson.

"AAH can help, for no other reason than its need to protect the income streams of the Lloyds chain. AAH negotiating on behalf of Lloyds together with a Link estate of over 2,500 other pharmacies presents a powerful force."

Making the Link

The millennium bug is not a bug at all but a problem brought about by under-investment in IT. With Link, AAH has faced a two-fold problem:

- pharmacists who have been notoriously bad at updating ageing hardware
- the basic operating system.

All Link computer hardware will have been replaced by millennium compliant machines by August. Software was upgraded last month with the issue of the 845 update.

A new Windows-based programme will be rolled out in the autumn – LinkScripts2 – which will allow for multitasking and the creation of networks within the pharmacy.

FSM, a system which provides EPoS type data on stock movements and enables the use of the dispensing computer to re-order front shop lines, will be launched next month.

Unlike EPoS, FSM handles only stock movements. Cash is handled by the existing till. The cost of FSM is about one third of that of EPoS.

AAH is moving rapidly to providing a range of head office facilities, but since the ideal environment for them is Windows, they will become available in conjunction with LinkScripts2.

AAH ploughs £45m into infrastructure

AAH Pharmaceuticals is investing £45 million in its distribution network up to 2001, by which time the company will have the most modern set of warehouses in the country, claims Mike Ward, chief executive of AAH.

Mike Ward, chief executive of AAH plc

Under construction is the new Midlands depot. It will be the most highly automated within the Gehe group when it opens in December.

Warehouse developments are underway in Tamworth and Warrington, which will be complete in early 2000. Further projects are on hand to automate Ruislip and Bristol.

Mr Ward told the Convention he was "delighted" with the progress of the Community Health Services initiative. "This augurs well for the future, because it is in this area that the pharmacist is going to have to change to achieve his rightful position in the centre of healthcare," he said.

The discount clawback is "indefensible", he said, but everyone should recognise it will continue. "I would urge you not to accelerate it."

AAH has just completed a major round of lobbying on the Health Bill to "prevent inclusion of clauses which would have allowed local authorities to grant pharmacy contracts to who ever they wished.

"We are also aware that much pressure continues to be applied to government to deregulate the licensing system [for NHS contracts]. We want to see the continuation of this just system," he added.

The future in pharmacy is not about discounts. It is about increasing other forms of income – from professional services, front shop management and other areas which the Government cannot take away.

The future is bright but government must be persuaded of this view. "Core to this is a unified voice... We are committed to a more consensus view within the industry," said Mr Ward.

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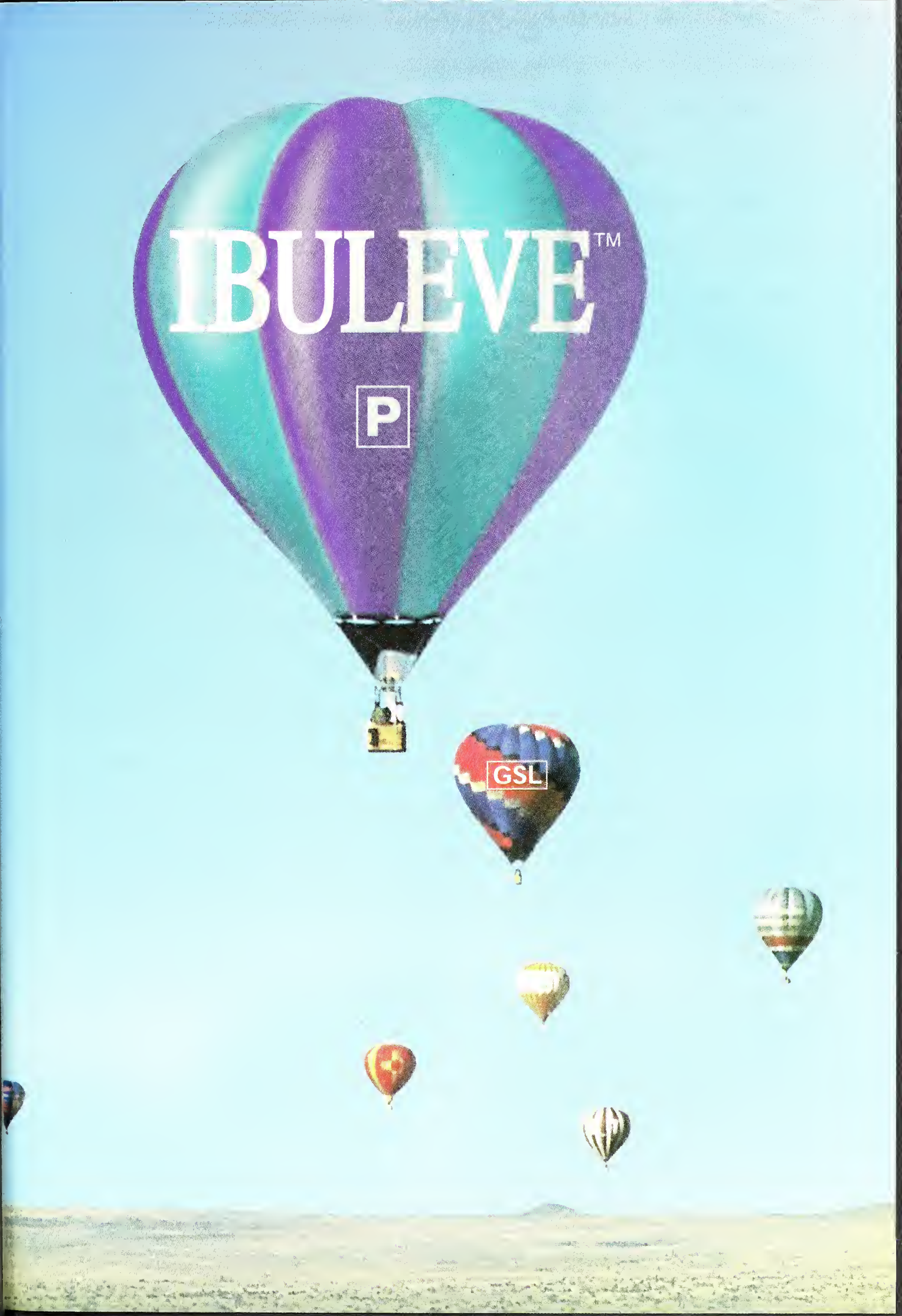
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Practice to People

From practice to people

John Williams, proprietor of Llanharry Pharmacy, Llanharry, Mid-Glamorgan, reports on progress with a prescription writing audit which he hopes will lead to doctors writing more accurate prescriptions. He was funded as a runner-up in the Glaxo Wellcome *Chemist & Druggist* 'From Practice to People' Awards 1998

Towards better script writing

Most research has concentrated on clinical aspects of prescribing. Practising pharmacists, however, spend a great deal of time and effort clarifying prescriptions, so that what the doctor intends the patient to take is the same as the medicine the pharmacist dispenses, and is taken at the correct dose.

Spending time advising trainee GPs about the technical aspects of prescription writing should result in doctors being able to concentrate on the clinical aspects of prescribing, confident in the knowledge that their prescriptions are technically accurate. Other advantages of making sure prescriptions conform with the *BNF* recommendations are:

- a reduced need for pharmacists to refer to the doctor
- reduced delays for the patient
- improved patient confidence in the doctor
- fewer problems for the Prescription Pricing Authority. This aspect may become more important when prescriptions are electronically transferred
- doctors could be made more aware of what can and cannot be prescribed.

John Williams aims for accuracy in prescriptions

Evaluation

My original proposal was to evaluate technical aspects of prescription writing and develop a training protocol.

After discussions with local doctors, I looked at a specific area of prescribing - paediatric medicine - to assess the extent of the problem, dividing a representative sample of prescriptions into medicine types (figure 1).

I then examined prescriptions for paediatric paracetamol because: there were a large number of them; it was prescribed by all the doctors so the survey would be anonymous; and paediatric paracetamol had been in the news with the withdrawal of certain batches of Calpol.

To get a larger sample and to give the survey further anonymity, I recruited the help of other pharmacists, to whom I am very grateful.

I noted whether the prescriptions:

- were legible
- carried the patient's name, address and date of birth
- carried the correct dose for age, following *BNF* recommendations
- had no dose, the words 'as directed' or no maximum dose if the direction was 'every four hours'.

I also considered whether the higher strength paracetamol (250mg/5ml) would have been more appropriate.

Using the above criteria, the survey showed that only 34 per cent of prescriptions were complete (figures 2 and 3). As the audit involved several pharmacies, the results were anonymous so no single doctor or practice could be blamed for the errors.

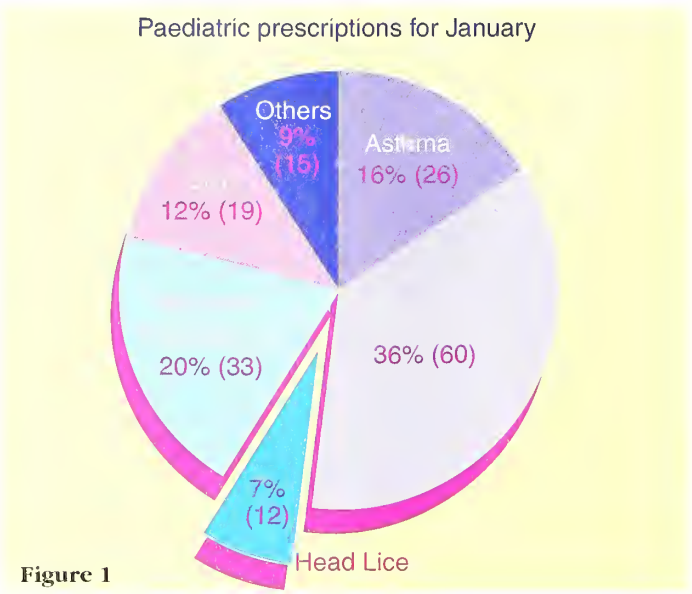


Figure 1

My task now is to achieve my goal of more accurate prescription writing by trying a non-confrontational approach with doctors. By presenting the anonymous findings and explaining the problems incomplete prescriptions cause, I hope prescribers will become more aware of their errors and correct them. Opposite is a possible letter that could be sent to doctors. A further audit will be needed to see if the desired outcome is achieved.

In my health authority over 27,000 prescriptions are written for paediatric paracetamol. If only a small proportion of the 66 per cent incorrect prescriptions result in the wrong dose being given, then this should be a cause for great concern.

I have sent a copy of my survey to the health authority, proposing that regular audits are carried out. With appropriate funding, a newsletter could be circulated to all prescribers. The criteria for further audits may

A letter that could be sent out to prescribers

Dear Dr Scribble

I have recently carried out a survey of prescriptions written in your health authority. The results are shown in the enclosed charts. The data has been collected from several pharmacies and is not specific to your practice. If you would like specific data, it may be possible to arrange a more detailed audit for your practice.

The results show a large percentage of prescriptions do not conform to the *BNF* recommendations. This may cause problems for the pharmacist, the Prescription Pricing Authority and – most importantly – the patient. I am sure you wish your patient to receive the right medicine at the dose you intended.

I hope this information, if you find it applicable to your practice, will assist you with your prescription writing.

Yours sincerely

differ from mine, as different priorities are recognised.

Excellent packages are available from the National Pharmaceutical Association, which are useful for any pharmacist wishing to get involved with the training of doctors and their receptionists in prescription writing.

Pharmacists are in a unique position in that their specialist knowledge of medicines and medicines law enables them to check prescriptions – a fail-safe for patients, doctors and the PPA.

Over the years there has been much talk of the pharmacy as the first port of call for patients. I regard pharmacists as the last health professional patients see before they take their medicines. Pharmacists must use their unique training so they are the final safeguard between the patient and a potentially fatal medication error.

Further developments

A similar survey to the above could look at insulin, where anecdotal evidence suggests there is much over-prescribing and wastage. The evidence is based on the quantities of insulin returned by patients for destruction. Between ten and 25 vials have been returned to me and a colleague told me of a patient who returned over 100 vials (worth about £10 each).

A major pharmaceutical company has expressed interest in helping me to develop a computer training package to aid prescribers with prescription writing, not an insignificant offer as development costs could reach £20,000.

I hope to contact companies who design computer programs for doctors' surgeries to discuss the possibility of developing programs that prevent incomplete prescriptions from being issued.

If pharmacists become involved in training other health professionals in prescription writing, then it will be difficult to argue a case against pharmacists prescribing in their own right.

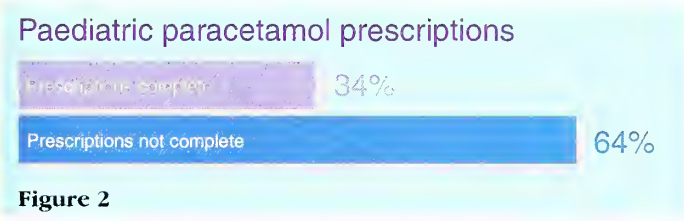


Figure 2

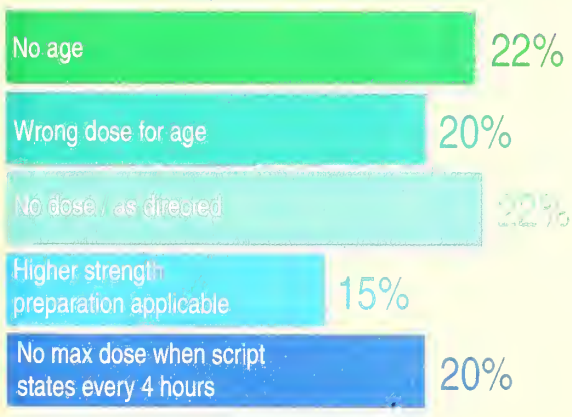


Figure 3

Dobson stirs up parallel import storm

Parallel importers are fighting health secretary Frank Dobson's proposal to curb their sales.

Mr Dobson is trying to broker a deal with pharmaceutical manufacturers: if they help to cut the NHS drugs bill, the Government will try to reduce parallel imports through the Pharmaceutical Price Regulation Scheme.

At the recent annual dinner of the Association of the British Pharmaceutical Industry, Mr Dobson said for every £1 the NHS saved from PIs, the pharmaceutical industry lost £6 (*C&D* April 17, p24).

He admitted, however, that government curbs could be contrary to the EU's free market principles, and that any changes would have to comply with EU law.

The timing of his speech is unfortunate, from parallel importers' point of view, because were scheduled to give evidence on May 11 to the House of Commons trade and industry committee inquiry into trading, trademarks and competition.

John Barker, chairman of the Association of Parallel Importers (API) – whose members account for 95 per cent of the value of licensed EU-based PIs in the UK – said he was alarmed by Mr Dobson's comments.

He stressed that EU law permitted PIs and that the PI industry benefited the Government and taxpayers:

- through the clawback. Cheaper PIs, whose prices are taken into account in the clawback, save the Government the equivalent of 2 per cent of the NHS' drugs bill each year
- by making the UK pharmaceutical market more competitive and helping to restrain the prices of specific drugs
- by providing work for thousands of people in the UK and paying taxes without repatriating any profits.

The API was particularly concerned by an article in a national newspaper, which claimed that parallel imports cost the pharmaceutical industry around £500-£600 million a year. "This is untrue and has not been substantiated by any proper means and/or made available in the public domain for open discussion," said Mr Barker.

The API said the estimates it had seen, taken from research funded by pharmaceutical manufacturers, related only to the losses suffered by individual companies.

Intercare, a company specialising in generics and PIs, reckons the UK PI market was worth £300m last year.

"The research-based industry overestimates the volume and value of the trade, using unreliable data from sources which admit that the figures used are, at best, extrapolated estimates," said Mr Barker. "To our knowledge, no major pharmaceutical company has ever been able to quantify a reduction in its research and development as a direct consequence of the parallel trade in its products."

Mr Barker has written to Mr Dobson to arrange a meeting about PIs.

The ABPI, meanwhile, has urged the Medicines Control Agency to increase inspections of parallel import drugs to ensure they are meeting safety regulations, especially regarding labelling.

While the ABPI admits it does not have precise figures on PI sales because the market is hard to quantify, it said the national paper's estimate was broadly accurate.

PIs, it added, took up half the sales of some top branded ethicals.

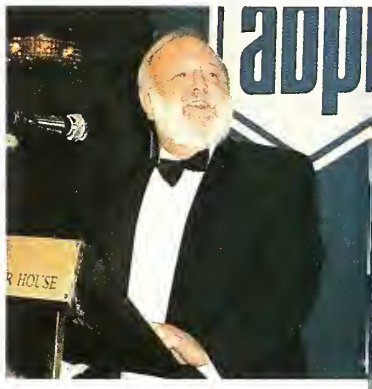
The idea that PIs created a more competitive market place was "rubbish".

"The [pharmaceutical] industry is extremely competitive anyway," said the ABPI. "The PPRS effectively controls prices by capping manufacturers' profits. Almost every medicine has an equivalent and if it doesn't, the company concerned is always looking over its shoulder for one that could be launched any moment."

It said that PIs also affected pharmaceutical manufacturers' R&D expenditure because, by reducing potential profits, they ate into R&D reserves.

"The industry's spending £7 million a day on research – parallel importers don't research anything," it said.

- The ABPI will be one of the headline partners of the Millennium Festival of Medicine, which will include a conference from November 6-10, 2000.



Frank Dobson, health secretary, may have to explain the Government's position at a meeting with parallel importers

IN BRIEF

April healthcare sales

Pharmacies' healthcare sales showed "reasanable grawth" in April, reparts British Retail Cansartium's latest retail sales manitar. Cosmetic sales were mixed, depending an the pramatianal affers, while those of perfumes were disappainting overall.

Kodak in £3m Dome deal

Kadak has signed a £3 millian deal ta give it exclusive photographic rights at the Greenwich-based Millennium Experience. Kodak products, ranging fram film ta batteries, will be available exclusively within the Dome's phata-graphic categary.

Nycomed sells pharma stake

Nycamed Amersham, the healthcare and diagnostics group, is selling its majority stake in its pharmaceutical business ta Nardic Capital, a Swedish venture capital group, far £340 million.

Sir Richard Sykes wins award

Sir Richard Sykes, Glaxa Wellcame's chairman, has been named Business Leader af the Year.

Medielite launches blood sugar and fat testing kits

Northolt-based Medielite, a wholesaler specialising in electrical appliances, will launch blood sugar and fat testing kits next week.

John Merrett, Medielite's sales director, denied that the kits were a radical departure for Medielite, which used to deal with traditional electrical appliances. "We're seeing our business driven more by diagnostic products that have a strong synergy with pharmacies," he said.

The wholesaler is launching the Ultimate Scale 2000, manufactured by Tanita and retailing at £49.99. This machine measures the customer's height and body fat percentage.

Medielite's blood sugar testing kit, produced by Roche, comprises two models: the Glucotrend soft test system retailing at £29, and a premium model, rsp £49.

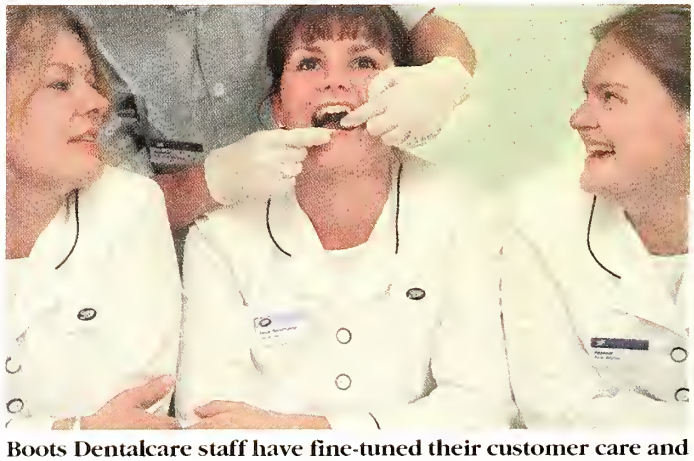
Pharmacies can buy a wholesale pack comprising five soft test systems and one premium model.

Mr Merrett said the blood sugar kits were ideal for pharmacists because of their professional healthcare image. "Up until now consumers have gone to department stores, but they haven't been given advice when they buy the units," he said.

Pharmacists, he added, could order the kits in time for National Diabetes week (June 7-11). Roche will be running press advertising on June 6.

While stocks last, Roche will also offer customers the premium model for £34 and the soft testing unit for £14.99. Pharmacists selling the units at the discount price will be asked to fill in a leaflet supplied by Roche, who will refund them £15 for every unit sold.

Pharmacists, meanwhile, will also be able to buy the wholesale packs at a 15 per cent discount.



Boots Dentalcare staff have fine-tuned their customer care and are now practising it at the chain's first dental practice, which opened in Milton Keynes on Monday. The practice employs four dentists, five hygienists, six dental nurses and four support staff, charging £25 for a routine dental examination

West Midland Co-op launches toiletry price war against superstores

West Midland Co-op (WMC) is slashing prices on toiletries by up to 60 per cent during the spring and summer to combat competition from superstores.

WMC, which owns 11 pharmacies in Wolverhampton, Walsall, Cannock and Kidderminster, tested the promotion in April and decided to extend it because the response was so good.

Many brands, it said, were now retailing at £1 per item. These included Insignia Body Spray 150ml, Wella Experience 2 in 1 250ml and Slazenger Body Spray 150ml.

WMC said the promotion was designed to remind customers that its pharmacies stocked much more than medicines.

Karen Belstone, merchandiser for WMC's pharmacy division, said too many people still thought they should go to a pharmacist only to collect a prescription, or to ask for advice. All WMC pharmacies also stock a wide range of toiletry lines.

"People have possibly forgotten that there's so much more to their local pharmacy and are routinely buying these items with their weekly or monthly shop at the larger superstores," she said. WMC, she added, was showing that it could compete against superstore prices while still offering traditional corner shop convenience.

The offers are limited to four of each product per person per visit.

Avicenna offers pharmacy retail courses

Avicenna Pharmacists' Associates, the pharmacy group, has introduced a training programme for pharmacy owners, managers and staff.

The programme consists of half-day and full-day practical courses on the internal marketing and merchandising of pharmacies, including self management and using planograms. Each course will be presented in hotels within the M25 belt, where around 95 per cent of Avicenna's 270 members are located.

Ian Glass, of Pharmacy Marketing Services, will evaluate each pharmacy involved and give advice on external marketing. He will also point out other ways of improving each pharmacy's productivity and profitability.

Avicenna said that pharmacists were recognised as good buyers, but not very good sellers. Around 80 per cent of customers visiting a pharmacy for prescriptions do not buy any other items, according to research. "Yet when an independent is taken over by one of the major groups, there is invariably an increase in OTC sales," said the group.

The group will subsidise the first employee of each pharmacy by £100 to attend the course, and subsequent employees by £20.

Avicenna's presentation, held over the May Day weekend, attracted around 120 delegates, who heard presentations from Mr Glass and David Leggett, Moss Chemists' space planning manager, on the principles of pharmacy marketing.

Shiraz Hirji, a partner at Cartwrights Accountants, gave a speech on how to minimise the impact of tax liability at retirement and death by using retirement relief, taper relief and trusts.

(l-r) Duncan Smeaton, Avicenna's executive director; Shiraz Hirji, a partner at Cartwrights Accountants; Hussein Esmail, Avicenna's chairman; Salim Jetha and Shiraz Jiwani, directors

Hussein Esmail, Avicenna's chairman, said: "It is essential to the future of independent pharmacy that we take a more analytical approach to retailing skills and that we use the management tools that have made major groups successful to enhance our professional position."

COMING EVENTS

MONDAY, MAY 17

Bromley Branch, RPSGB, at the Frognal Centre, Postgrad Education Centre, Queen Mary's Hospital, Frognal Lane, Sidcup, 7 for 8pm. 'Importance of wound formulation and maggots'.

Slough & District Branch, RPSGB, at the John Lister Postgrad Centre, Wexham Park Hospital, Slough, 7.15 for 8pm. 'Management of prescribed medicines: Gastro-Intestinal medicines - how can we help?'.

WEDNESDAY, MAY 19

West Metropolitan Branch, RPSGB, at the Royal Brompton Hospital, Sydney Street, Chelsea, London SW3, 7 for 8pm. AGM followed by 'Getting High on Plants'.

Birmingham LPC at the Birmingham Medical Institute, 36 Harborne Road, Edgbaston, 7 for 7.30pm. Annual Community Pharmacy Conference.

THURSDAY, MAY 20

Bedfordshire Branch, RPSGB, commemorating 75 years there will be a visit to the restored pharmacy at Hitchin Museum, and a meal.

NICPPET at the Beeches, Hampton Park, Belfast, 9.30am-4.30pm. 'Microsoft Word' (IT Module Unit 6).

AAH in gas/electricity deal for Vantage members

AAH Pharmaceuticals has arranged a deal with Eastern Energy - formerly Eastern Electricity - that could save Vantage members up to 15 per cent on their electricity and gas bills.

Vantage members are being asked to phone or fax Eastern Energy with their latest electricity/gas bills to receive a quote on the discounts available.

These discounts are worked out on the customer's tariff area - AAH said most customers could save up to 15 per cent.

In areas where a discount has already been negotiated with the current electricity supplier, AAH said Vantage pharmacies could still save money.

Customers with more than ten stores can ask for a single bill, itemised for each store.

EE's number is, 0845 600 1998. All calls are charged at local rates and an EE/Vantage team is there to provide advice.

UniChem financial services is offering pharmacies electricity discounts through Southern Electric.

Portsmouth-based wholesaler Graham Tatford has changed its name to Tatfords. Its van colours have been altered from blue to white. From June 1, Tatfords' main switchboard number will become 023 92288850, and for orders 023 922 88860

Superdrug profits held back by health and beauty investment

Superdrug's operating profits remained flat at £41.1 million on sales of £798.6m, up 6.6 per cent, for the year to January 30.

Kingfisher, the chain's parent, said Superdrug's profits had been held back by investment designed to reposition the outlets as health and beauty specialists.

Like-for-like sales grew 5.4 per cent and they were "comparatively good" during the second half of the year, when consumer spending slowed down amid fears of a recession. Kingfisher said customers had "sought out value" at Superdrug and Woolworths.

Superdrug claimed to have a 10.7 per cent share of the health, beauty and toiletry market last year - up 0.4 percentage points on 1997, and expects to have 11 per cent this year.

A quarter of Superdrug stores had a pharmacy at the year end - the company's pharmacy numbers were boosted by 47 during the period to 177.

Kingfisher and Asda are negotiating a merger to form a group.

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To: Business Link, CHEMIST & DRUGGIST, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW.

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Pharmacy in an old age

Jacky Holton's business in Sedbergh has been a pharmacy for over 100 years. But recent research discovered the building's history dated back to the 15th century

When Jacky Holton bought a pharmacy in Sedbergh, Cumbria, she realised that she was purchasing a historic building. But it took a visit from BBC2's 'House Detectives' to unearth its fascinating 500 year history.

The building has previously been used as a textile mill, a fortified 'tower house', and possibly a hiding place for Bonnie Prince Charlie.

Sedbergh Chemist and Druggist was in a poor condition when Jacky purchased it four years ago. The roof leaked, the floorboards were rotting, and the chimney was falling down. Jacky and her husband Chris, a civil engineer, have recently finished restoration work to return the pharmacy to its former Victorian glory. They have also restored the first and second floors and made it their home.

The restoration work uncovered a host of interesting original features and artefacts. Hidden behind layers of plaster were windows, old coins, musket balls, and an old spice cupboard. The first floor had served as a stockroom and was full of invoices and paperwork. It contained a letter dating back to World War II from a supplier claiming it could not fulfil its orders due to enemy bombing.

Lorna Sedgwick, pharmacy technician (left), with Jacky Holton at the original Lowis' display cabinet

Calling the detectives

Restoring the pharmacy "became a passion", says Jacky, and to find out more about its history she contacted 'The House Detectives'. Jacky's was one of only six buildings accepted by the programme from 1,500 applicants. The programme has two 'detectives' – historians Mac Dowdy and Judith Miller who "descend on a house and go over it with a fine tooth comb to discover clues as to its history".

For most of its pharmaceutical life, 41 Main Street was owned by the Lowis family. The shop used to be divided in two, with one half acting as Fred Lowis' chemist shop and the other as his brother Teddy's cobblers.

During the early 19th century, the building was used as a drapers and at the end of the 18th century it was a textile mill. Before this, it played host to a candlemaker and in the late 17th century it was a hosiery shop.

In the 15th century the premises acted as a 'tower house' – a fortified building usually used as a lookout and for defensive purposes. Mac Dowdy suggests it was used to house tax collectors, who "have always been unpopular people".

Window on history

Interesting features of the house include engravings on the upstairs windows. One, dated February 23, 1819, advertises Thomas Worthington's glazing services, and another is a rhyme in period humour:

Since one stone cutts the most obdurate glass,
What need of two to pierce the tender lass?

Mr Dowdy suggests that the word 'ball' should be substituted for 'stone'.

Rumour has it that the large corbelled wall chimney served as a hiding place for Bonnie Prince Charlie in 1745 during the Jacobite rebellion, although the House Detectives were "inconclusive" on this point. A recent discovery that he had an illegitimate daughter in Windermere means that the Prince would have had to secretly pass through the area to visit her.

Judith Miller from the programme spent a week with Jacky and Chris helping to choose suitable fabrics, materials and colours to retain an effective period look to the pharmacy. All the original fixtures and fittings were still in the pharmacy as recently as 12 years ago and, although there are only a few left, more antique pharmaceutical items are constantly being added.

Customers donate old medicine jars and containers and Jacky and Chris collect their own from antique shops. The drug run behind the counter is perfectly preserved although a far larger one was sold to an Irish museum before Jacky bought the business. The 'House Detectives' discovered a display case in a local antique shop which had come from Lowis' pharmacy and has now been returned to 41 Main Street.

Both photos: Stan Clare

(left to right) Jacky Holton, Christine Gibson, pharmacy technician, and Lorna Sedgwick, pharmacy technician

Famous pharmacy...

The TV programme has created a lot of publicity for the pharmacy and attracted visitors from Australia, Belgium and Holland. Hikers pass through Sedbergh as it borders the Yorkshire Dales National Park. It's good for business as "a lot of people have blisters when they get here", says Jacky.

A brochure entitled 'Behind the Chemist Shop', based on the House Detectives' findings, has raised nearly £1,000 for cancer charities. An open day on May 29 will allow visitors to look around the building in return for a donation to charity.

Jacky's is the only pharmacy for 12 miles and provides a delivery service and oxygen supplies as well as serving Sedbergh Public School, whose famous old boys include Will Carling and Ted Heath.

Sedbergh Chemist and Druggist is Jacky's first business. After graduating from Bath University in 1991, she did her pre-registration year at the John Radcliffe Hospital in Oxford. Jacky also worked at the Churchill Hospital in Oxford before getting married and having a year's "honeymoon", during which time she travelled the world. Before moving to Sedbergh, she had worked in an independent Sedgefield pharmacy for three and a half years.

Copies of 'Behind the Chemist Shop' are available from Jacky Holton on 015396 20270. It costs £2 and profits go to cancer charities.

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